Summary Report/Sommaire and Implementation Report

Moving Forward

Strengthening Health Planning In Ontario

A Report by the Joint Task Force to the Minister of Health

The Association of District Health Councils of Ontario and The Ministry of Health

1993

Ontario

The Honourable Ruth A. Grier, M.P.P.
Etobicoke-Lakeshore,
Minister of Health,
Province of Ontario,
10th floor, Hepburn Block,
80 Grosvenor Street,
Toronto, Ontario.
M7A 2C4

Dear Ms. Grier:

We are pleased to submit this report of the District Health Councils/Ministries Joint Task Force (JTF) for your consideration.

The JTF and its Working Groups worked diligently over the last six months to define the practical roles and mandates of district health councils as they relate to health system planning and the Ministry of Health and, potentially, the Ministry of Community and Social Services (MCSS); to recommend adequate resourcing for these roles and mandates; and to maximize positive relationships among these three partners in health and social services system reform.

We have appreciated the support and encouragement your Ministry has given us and hope that our report merits the trust that was placed in us.

Respectfully submitted,

Jodey Porter
Jodey Rorter

Co-Chairs

L. Joy Warkentin
L. Joy Warkentin

Jane Bartram
Jane Bartram

Colleen Blight
Colleen Blight

David Bogart
David Bogart

M. Louise Demers
M. Louise Demers

Jessica Hill
Jessica Hill

Judi Richter Jacobs
Judi Richter Jacobs

Perry Kendall
Perry Kendall

Pierre Lalonde
Pierre Lalonde

J. Douglas Lawson
J. Douglas Lawson

Marlene Longdon
Marlene Longdon

Betty McIver
Betty McIver

Manty Nagawker
Manty Nagawker

Ken Whiteford
Ken Whiteford

Lorne Zon
Lorne Zon

Moving Forward: Strengthening Health Planning In Ontario

Contents

Summary Report

Sommaire

Implementation Report

Appendices

List of Charts and Tables

Order Form

Moving Forward: Strengthening Health Planning In Ontario

Summary Report

Introduction

The Joint Task Force (JTF) is a joint venture by the Association of District Health Councils and the Ministry of Health (MOH), with the Ministry of Community and Social Services (MCSS). Established in December 1992, it has a mandate to examine the roles of DHCs in the health system. The Joint Task Force's Terms of Reference and a list of its members are included as an appendix to this summary.

The need for direct and timely action on health system reform has never been as evident and urgent as it appears today. DHCs and Government alike have demonstrated their readiness and willingness for change.

The Government has endorsed a new ***Vision of Health*** and Health Goals for the province. The Ministry of Health is further developing the reform agenda based on its Goals and Strategic Priorities. The District Health Council (DHC) system has acquired almost twenty years of experience through which DHCs have developed the capacity to take on a leadership role in health system planning.

The JTF has recognized that in order for District Health Councils to fulfil their responsibilities as leaders in health system planning and reform, there must be strong commitment for change from all the partners in the process.

This report is the first step in that partnership. It reflects the commitment and desire for change by people from the Ministry of Health, the Ministry of Community and Social Services and District Health Councils. It should also be noted that the process that the JTF undertook to formulate this report included the perspectives of every region in the province.

The Need For Action

The Government of Ontario endorses a ***Vision of Health*** that emphasizes a broader definition of health. This Vision recognizes that strategies which deal with the determinants of health are a principal means of improving the health and well-being of Ontario residents.

There is also a need for strategic health planning to improve the organization and management of the system. This will help maximize the quality of care and efficiency within the resources that are available.

The Ministry of Health, the Ministry of Community and Social Services and District Health Councils all recognize that attention to the social determinants of health is a critical strategy to improve health status and to balance the health and social services sectors.

The Mandate of District Health Councils

The Minister of Health has designated District Health Councils to lead health planning, both locally and regionally. DHCs' intended responsibilities and functions haven't changed very much since they were first proposed by the Royal Commission on Health Services in 1964. What *has* changed significantly is the context in which DHCs must plan. The current reform strategies of the provincial Government — based on the fiscal, social and political realities of the 1990's and beyond — mark the emergence of a transformed health system.

The Impetus for Change

The economic recession which has continued in Ontario through the early 1990's has increased the need to reform the health system. The reforms deal with the very definition of health and with the basics of the health system as we know it. District Health Councils are providing advice to the Government in an economic climate which has shifted the planning focus from new and expanded services to system restructuring and resource allocation. Within this climate, DHCs have tried to take action on their original and enhanced roles. However, there is a need to focus more attention on the resources, policy framework and political mandate that are necessary for action.

All these factors mean that, jointly, DHCs and the Government have to increase their capacity to be facilitators, adjudicators and advocates in restructuring for a sustainable health system.

The JTF knows and appreciates that the Minister of Health recognizes that the current DHC organization and structures cannot deal with the greater demands and responsibilities without a strengthened and coordinated planning infrastructure, appropriate resources, and a mandate that is clearly stated in regulation and policy.

A Note Concerning Devolution

During the JTF's deliberations, Ministry of Health representatives set out the parameters for change for DHCs. This clearly showed that devolution of management and fiscal authority is not a Government priority in the short or medium-term. Rather, the Ministry said it expects District Health Councils to take on stronger planning functions. This includes the authority to give advice to the Government on allocating and reallocating designated resources.

The Joint Task Force appreciates the need for the Ministry to set out these limits at this time. However, DHCs will rely on the Government to discharge its obligations in policy development and fiscal management in a timely and responsible manner so that they can fulfil their responsibilities effectively.

Our Visions and Values

The JTF members recognize that we can't have a viable, high-quality health system in Ontario without, collectively, changing the way we do business. The JTF also recognizes that the goals we set today to achieve change will form the basis for tomorrow's health system.

The ***Vision of Health*** sets out what the JTF believes is the primary goal of health system reform. The ***Role of Planning*** explains how the JTF sees achieving the Vision.

The Vision of Health

The Joint Task Force adopts the following ***Vision of Health*** which the Premier's Council on Health Strategy developed and that the Ministry of Health endorses.

We see an Ontario in which people live longer in good health, and disease and disability are progressively reduced. We see people empowered to realize their full health potential through a safe, non-violent environment, adequate income, housing, food and education, and a valued role to play in family, work and the community. We see people having equitable access to affordable and appropriate health care, regardless of geography, income, age, gender or cultural background. Finally, we see everyone working together to achieve better health for all.

The Role of Health Planning

Planning is the link between recognizing the determinants of health and taking action on them to improve the health of everyone who lives in Ontario.

Planning involves developing clear, practical strategies to achieve the goals that the ***Vision of Health*** sets out. It is essential to get the most from Ontario's health system in terms of care, efficiency and cost-effectiveness.

The Joint Task Force envisions an Ontario where the health of the population is promoted through healthy public policy, a focus on the environmental, economic, social and educational determinants of health, and an appropriately planned and designed health system.

Strong community-focused planning, on a local and regional basis, is essential to facilitate the necessary changes, understandings, consensus-building and resolution of difficult issues, and gives a context to resource allocation and provincial policy development and planning.

The current and continuing need to reform Ontario's health system, in the context of the determinants of health, means that health planning bodies need to have the authority to lead local and regional restructuring, and influence provincial directions.

Achieving the Vision

Achieving the ***Vision of Health*** through planning means satisfying the following conditions:

- There must be effective and meaningful processes that let communities achieve optimal health through the availability of high-quality, efficient health services which respond to their needs.

- There must be fostering and respect for the differences and uniqueness of DHCs that reflect the diversity of communities across the province. At the same time, there must be a consistent core of competencies and responsibilities across all DHCs.

- There must be clear definitions and mutual agreement about the day-to-day relationships and accountability that DHCs have to their communities and to the Minister of Health.

- DHC volunteers must have a commitment to the goals of achieving the ***Vision of Health*** and health system reform and have their role recognized and valued by the Minister and Ministry of Health; in order to provide high quality advice, volunteers must be supported by capable staff and adequate resources.

- Partnerships between stakeholders must be built on trusting and respectful relationships, with regular feedback and ongoing evaluation of the relationships.

- A commitment to system reform and effective management of change and uncertainty must be prerequisites of participation by all partners and stakeholders in the health system.

- Partnerships at the local, regional and provincial level, plus effective planning processes at each level are necessary to planning for the health system.

The JTF has developed the following planning framework to guide the achievement of the full potential of DHCs and the Ministry of Health for health system planning within a "determinants of health" framework.

The Planning Framework

Planning Roles and Responsibilities

There is a significant interdependence among the groups who participate in the policy and planning process. Table I shows the planning framework that JTF has developed to clarify the responsibilities of DHCs within the broader health system.

The framework sets out the five "what's" of policy development and implementation — ***strategic policy, planning framework, implementation plan, local/regional planning*** and ***local service delivery***. At each stage, there is a designated "lead" from among the planning partners, with the other planning partners all participating and providing support and input. As the planning framework indicates:

The Ministry of Health

- starts the process of strategic policy development within Government, based on the needs that consumers, DHCs and providers identify, and
- leads the development of a planning framework and implementation plan for each identified policy initiative.

DHCs

- are the interface between the Ministry's policy and guidelines and the priorities and needs of their local communities, and
- are responsible for incorporating Government policies into the planning process at the local and regional levels.

Providers of care and support

- are responsible for managing and delivering high quality and efficient services, based on provincial and local policies and guidelines and, where applicable, professional standards of practice.

Consumers

- The Ministry, DHCs and providers are, of course, ultimately accountable to consumers.

Table I: Policy Development and Implementation Framework

WHAT \ WHO	Government MOH	Health Strategies Group MOH	Operations MOH	DHCs	Providers
Strategic Policy	Lead	Support	Support	Support	Support
Planning Framework	Support	Lead	Support	Support	Support
Implementation Plan	Support	Support	Lead	Support	Support
Local/Regional Planning	Support	Support	Support	Lead	Support
Local Service Delivery	Support	Support	Support	Support	Lead

Repositioning District Health Councils

For DHCs to function in the health system as lead planning bodies, they must have the capacity to deliver on their responsibilities. Without adequate resources, DHCs won't be able to meet their responsibilities effectively or efficiently.

The JTF has identified four central themes that must be addressed to prepare and support District Health Councils to accomplish their roles and responsibilities as designated lead planners. These are:

I. Authority and Leadership
II. Accountability
III. Regional Planning Capacity
IV. Linkages.

The JTF has set out a series of strategic directions that will support the achievement of each theme. It has also developed specific strategies for action and a set of necessary enabling mechanisms to achieve the ***Vision of Health Planning.*** (The strategic actions and enabling mechanisms can be found in the Implementation Report.)

Central Themes

I. Authority and Leadership

District Health Councils, as the clearly designated leaders for health system planning, will have the clear mandate to act stated in regulation and policy. This will facilitate and clarify the authority DHCs are being asked to assume in the allocation and re-allocation of resources within their local districts. DHCs will respond by further developing and refining the commitment and capacity of their volunteers and staff to effectively fulfil their mandate to provide the Minister of Health with sound advice.

Strategic Directions

1. The role of District Health Councils as the ***lead planning bodies***, responsible for planning a comprehensive health system, from both local and regional perspectives will be formalized through regulation and policy.

2. District Health Councils will be explicitly delegated the authority to advise the Minister about the allocation and reallocation of health system resources within their districts or regions.

3. DHCs will provide advice to the Minister regarding planning and policy decisions which affect local and regional health planning.

4. DHCs may also provide advice to the Minister regarding the allocation of resources at a provincial level.

5. District Health Councils will be empowered to operate at arm's length within the established accountability framework.

6. District Health Councils will further develop the commitment and capacity of their volunteers and staff to provide high-quality and sound advice to the Minister.

7. The Minister and Ministry of Health will consistently support and promote the roles of District Health Councils to all stakeholders in the health system.

II. Accountability

The accountability of DHCs to both their local communities and the Minister of Health requires them to have latitude in the planning for local needs within provincially determined policies, guidelines and standards. In order to function credibly and effectively, DHCs and the Ministry must ensure clear channels of communication are established both between themselves and with local communities.

The planning and decision-making processes of DHCs and the Ministry of Health must be defensible to the public they serve, with strong evaluative components built-in. DHCs will facilitate strong local input and participation through broad community membership that reflects a diversity of skills, experiences and interests and through enabling mechanisms to orient and educate Council members in fulfilling their responsibilities.

The Ministry of Health will make determined efforts to ensure DHCs have predictability in the financial resources available to them in support of their planning activities.

Strategic Directions

1. District Health Councils will have the flexibility and latitude to plan for local needs and priorities within the framework of provincial policies, standards, guidelines and directions.

2. Clear channels of communication and consultation will be developed between the Ministry of Health and District Health Councils, and District Health Councils and their communities to enhance the effectiveness, accountability and ownership of DHC planning outcomes.

3. The planning and decision-making of DHCs and the MOH will be based on defensible processes and will incorporate an evaluation component of both the planning process and the outcomes.

4. District Health Councils will build a core of staff and volunteers who have an appropriate mix of skills, knowledge and experience to address the planning agenda and enable DHCs to fulfil their present and evolving roles and responsibilities.

5. DHCs will broaden membership to ensure volunteers of Councils and committees reflect the priorities and perspectives of the community at large.

6. The MOH will enhance the level of predictability of financial resources available to support DHC planning activities.

III. Regional Planning Capacity

DHCs must be involved in every step of the Policy Development Framework — as opposed to planning only for sectoral reform at the local level — if they are to be system managers. Successful undertaking of regional planning will ensure that all sectors are addressed but in a comprehensive and integrative manner. Regional planning has the potential to create greater economies of scale, and create greater equity across regions by making available services which may otherwise not have been possible.

District Health Councils will be the principal instruments for regional health planning, building on their collective strengths, relationships and resources. In order to be effective regional planners, DHCs require support from the Ministry in the form of enabling regulations, policies

and guidelines which facilitate the development of flexible models across the six provincial regions. This also creates a forum for DHCs to discuss and negotiate sharing of resources and possible rationalization of operations and programs to a regional focus.

Strategic Directions

1. The Ministry of Health will develop a clear policy and regulative framework based on identified planning principles which contains standards and guidelines for regional planning.

2. The Ministry of Health will develop policy and regulations which explicitly identify and authorize District Health Councils to be the ***principal regional planners*** for the health system.

3. Regional planning structures will build on the collective strengths, relationships, resources and expertise of existing DHCs to avoid creation of an added layer of bureaucracy, and will be flexible across regions to ensure responsiveness to local needs as well as provincial policies.

4. The JTF recognizes that, just as with all other components of the health system, DHCs too must collectively rationalize their structures, operations and decision-making.

IV. Linkages

Effective action on the determinants of health and a broader definition of health requires District Health Councils to actively develop local and regional health planning networks with other stakeholders. This includes those in sectors that have not traditionally been considered "health." District Health Councils can forge linkages through the development and implementation of comprehensive communications and marketing strategies which reach out to their communities. Such linkages must also occur at the Ministry level, particularly in the development of healthy public policy. Linkages are, by nature, two-way in that partners are open to giving and receiving advice.

Strategic Directions

1. District Health Councils will actively develop local and regional health planning networks with other stakeholders and partners in the planning process.

2. Linkages are two-way, therefore DHCs and the MOH will endeavour to be open to both ***giving*** and ***receiving*** advice and direction.

3. Where appropriate, the Ministry of Health will explore and explicitly identify the planning roles and responsibilities the Ministry has with other Ministries and sectors. In particular, the Ministry will develop linkages for joint policy development with MCSS and with the Ministry of Education in areas of common interest.

4. District Health Councils will explore and develop planning and information-sharing linkages with local offices of other Ministries.

5. District Health Councils will develop and implement comprehensive communications and marketing strategies which will actively reach out to their communities to forge stronger links.

Conclusion

Health planning is the necessary link between the ***Vision of Health*** for all Ontarians and the means by which it can be achieved. The work and process of this Task Force of the Ministry of Health, the Ministry of Community and Social Services and District Health Councils demonstrates the readiness to proceed in partnership towards health system reform.

L'honorable Ruth A. Grier, députée
Etobicoke-Lakeshore
Ministre de la Santé
Province d'Ontario
Édifice Hepburn, 10e étage
80, rue Grosvenor
Toronto (Ontario)
M7A 2C4

Madame la Ministre,

C'est avec plaisir que nous vous soumettons le présent rapport préparé par le groupe de travail mixte (GTM) des conseils régionaux de santé et du ministère de la Santé, avec la participation du ministère des Services sociaux et communautaires.

Le GTM et ses sous-groupes ont travaillé assidûment au cours des six derniers mois afin de : définir les rôles et les mandats que les conseils régionaux de santé seront appelés à assumer concrètement, relativement à la planification du système de santé et par rapport au ministère de la Santé ainsi qu'éventuellement au ministère des Services sociaux et communautaires; recommander l'affectation des ressources adéquates pour l'application de ces rôles et de ces mandats; et maximiser l'instauration de rapports positifs entre ces trois partenaires de la réforme du système des services de santé et des services sociaux.

Nous avons apprécié l'appui et l'encouragement reçus de votre ministère et nous espérons que notre rapport est digne de la confiance qui nous a été accordée.

Nous vous prions d'agréer, Madame la Ministre, l'assurance de notre haute considération.

Jodey Porter — L. Joy Warkentin

co-présidentes

Jane Bartram — Colleen Blight

David Bogart — M. Louise Demers

Jessica Hill — Judi Richtot Jacobs

Perry Kendall — Pierre Lalonde

J. Douglas Lawson — Marlene Longdon

Betty McIver — Manty Nagawker

Ken Whiteford — Lorne Zon

Aller de l'avant et consolider la planification de la santé en Ontario

Sommaire

Introduction

Le groupe de travail mixte (GTM) est composé de représentants de l'Association des conseils régionaux de santé de l'Ontario (ACRSO), du ministère de la Santé et du ministère des Services sociaux et communautaires. Ce groupe a été mis sur pied en décembre 1992 et s'est vu octroyer le mandat d'étudier les rôles conférés aux CRS dans le cadre du système de santé. Le mandat et la liste de membres du groupe de travail mixte sont joints en annexe au présent sommaire.

Le besoin d'instaurer des mesures directes et opportunes de réforme du système de santé n'a jamais été aussi pressant et évident. Les CRS ainsi que le gouvernement se sont déclarés prêts et disposés au changement.

Le gouvernement a adopté une nouvelle ***vision de la santé*** et des objectifs de santé pour l'Ontario. Le ministère de la Santé poursuit l'élaboration d'un programme de réforme à la lueur de ses buts et de ses priorités stratégiques. Le système des conseils régionaux de santé (CRS) a pratiquement vingt ans d'expérience à son actif, ce qui a permis aux CRS d'assumer un rôle de maître d'oeuvre en matière de planification du système de santé.

Le GTM a reconnu que pour que les conseils régionaux de santé puissent assumer pleinement leurs responsabilités en tant qu'initiateurs de la planification et de la réforme du système de santé, tous les partenaires jouant un rôle quelconque dans ce processus doivent s'engager fermement à effectuer des changements.

Ce rapport amorce ce partenariat et reflète l'engagement et le désir de changements exprimés par les représentants du ministère de la Santé, du ministère des Services sociaux et communautaires ainsi que des conseils régionaux de santé. Il est également à souligner que le processus entrepris par le GTM pour formuler ce rapport a regroupé le point de vue de chacune des régions de la province.

La nécessité d'agir

Le gouvernement de l'Ontario souscrit à une vision élargissant la définition de la santé. Ainsi, cette vision reconnaît que les stratégies qui portent sur les déterminants de la santé constituent un principal moyen d'améliorer la santé et le bien-être de la population ontarienne.

Il existe également un besoin d'élaborer un plan stratégique pour améliorer la structure et la gestion du système, ce qui permettra de maximiser la qualité des soins et l'efficacité en utilisant les ressources existantes.

Le ministère de la Santé, le ministère des Services sociaux et communautaires ainsi que les conseils régionaux de santé conviennent tous qu'il est crucial de tenir compte des déterminants sociaux en ce qui a trait à l'amélioration de la santé ainsi qu'à l'équilibre des secteurs de la santé et des services sociaux.

Le mandat des conseils régionaux de santé

Le ministre de la Santé fait jouer un rôle de premier violon aux conseils régionaux de santé en matière de planification des services de santé, et ce, tant au palier local que régional. Les responsabilités et les fonctions conférées aux CRS n'ont guère changé depuis que la Commission royale d'enquête sur les services de santé a recommandé leur mise sur pied pour la première fois en 1964. Ce qui ***a*** néanmoins considérablement changé, c'est le contexte dans lequel les CRS doivent effectuer leur planification. Les stratégies de réforme actuellement adoptées par le gouvernement provincial — axées sur les conditions fiscales, sociales et politiques des années 1990 et les conditions prévues au-delà — marquent l'apparition d'un système de santé repensé.

L'impulsion requise pour apporter des changements

Le climat de récession économique qui perdure en Ontario en ce début de décennie a accentué le besoin de modifier le système de santé. Or, cette réforme porte sur la définition même de la santé ainsi que sur les principes fondamentaux sur lesquels s'appuie le système de santé tel que nous le connaissons. Le climat économique a influé sur le rôle consultatif des conseils régionaux de santé vis-à-vis du gouvernement; de fait, les enjeux de la planification ne portent plus sur l'instauration et l'élargissement de services, mais bien sur la restructuration du système et l'affectation des ressources. Malgré ce climat, les CRS ont essayé d'agir en fonction de leurs rôles originaux et

agrandis. Il faut toutefois se concentrer davantage sur les ressources, le cadre conceptuel et le mandat requis pour passer à l'action.

Tous ces facteurs signifient que les CRS et le gouvernement doivent, conjointement, rehausser leur rôle de catalyseur, de juge et de représentant dans le cadre du processus de restructuration, visant un système de santé durable.

Le GTM sait et apprécie que le ministre de la Santé convienne que l'organisation et les structures actuelles des CRS ne leur permettent pas de composer avec une recrudescence d'exigences et de responsabilités avant de pouvoir bénéficier d'une infrastructure de planification plus forte et mieux coordonnée, de ressources appropriées et d'un mandat précisé dans des règlements et des politiques.

Une note sur la décentralisation

Au cours des délibérations du GTM, les représentants du ministère de la Santé ont indiqué les paramètres des changements pour les CRS. Il était clair qu'une décentralisation du pouvoir financier et de la gestion ne constitue pas une priorité à court ou à moyen terme pour le gouvernement. Les représentants du ministère ont déclaré qu'ils s'attendent plutôt à ce que les CRS assument des fonctions plus importantes en matière de planification. Cela comprend l'autorité nécessaire pour conseiller le gouvernement en ce qui a trait à l'affectation et la réaffectation des ressources désignées.

Le groupe de travail mixte comprend que le ministère ressente le besoin d'établir ces limites à ce stade-ci. Les CRS compteront toutefois sur le gouvernement pour s'acquitter de façon opportune et responsable de ses responsabilités en matière d'élaboration de politiques et de gestion financière, leur permettant en retour de s'acquitter de leurs propres responsabilités.

Nos visions et nos valeurs

Les membres du groupe de travail mixte reconnaissent que le système de santé de l'Ontario ne peut être rentable et de qualité supérieure sans que nous changions, collectivement, son mode de prestation de services. Ils reconnaissent en outre que les buts établis aujourd'hui pour apporter des changements formeront la pierre angulaire sur laquelle reposera le système de santé de demain.

La ***vision de la santé*** précise ce que le GTM considère comme le but principal de la réforme du système de santé. Le ***rôle de la planification*** explique la façon dont le GTM entend concrétiser cette vision.

La vision de la santé

Le groupe de travail mixte souscrit à la vision suivante de la santé, élaborée par le Conseil du premier ministre sur la santé et entérinée par le ministère de la Santé :

> *Nous espérons qu'un jour, l'Ontario sera une province où les gens vivront plus longtemps et en meilleure santé, et où les maladies et les handicaps auront été progressivement réduits. Une province dont les résidents auront la possibilité de vivre en bonne santé grâce à un environnement sécuritaire et non violent, un revenu, un logement, une alimentation et une éducation convenables, de même qu'un rôle familial, professionnel et social valorisant. Une province où chacun aura un accès équitable à des services de santé suffisants, abordables et adéquats, quels que soient sa région, son revenu, son âge, son sexe ou son origine ethnique. Enfin, une province où la collectivité veillera à ce que tous les citoyens vivent en bonne santé.*

Le rôle de la planification de la santé

La planification relie la phase portant sur la reconnaissance des déterminants de la santé et celle portant sur la mise en oeuvre de mesures permettant d'améliorer l'état de santé de toute la population ontarienne.

La planification requiert l'élaboration de stratégies précises et pratiques qui permettront d'atteindre les buts énoncés dans la ***vision de la santé***. Il est essentiel de retirer le maximum du système de santé de l'Ontario en matière de soins, d'efficacité et de rentabilité.

Le groupe de travail mixte croit que les mesures suivantes permettraient de promouvoir la santé de la population de l'Ontario :

- l'élaboration de politiques officielles favorisant la santé;

- la focalisation sur les déterminants environnementaux, économiques, sociaux et éducationnels de la santé; et

- l'instauration d'un système de santé adéquatement planifié et conçu.

Une planification solide, axée sur la collectivité, tant au palier local que régional, est essentielle pour les raisons suivantes :

- Pour faciliter l'apport de changements ainsi que l'atteinte d'ententes et de consensus, sans oublier la solution de problèmes importants.

- Pour donner un contexte à l'affectation des ressources ainsi qu'à l'élaboration de politiques et à la planification provinciales.

Le besoin de réforme du système de santé de l'Ontario qui a été relevé et qui perdure signifie, dans le contexte des déterminants de la santé, que les organismes de planification des services de santé doivent :

- détenir les pouvoirs nécessaires pour diriger la restructuration à effectuer aux paliers local et régional; et

- influer sur les orientations provinciales.

La concrétisation de la vision de la santé

Les conditions suivantes doivent être satisfaites pour que la ***vision de la santé*** puisse se concrétiser au moyen de la planification :

- Des processus efficaces et positifs doivent être en place afin de permettre aux collectivités de maximiser leur potentiel-santé grâce à l'accessibilité à des services de santé efficaces et de qualité supérieure qui répondent à leurs besoins.

- L'unicité et les différences des CRS reflétant la diversité des collectivités dans toute la province doivent être respectées et encouragées. Il doit également et simultanément exister un noyau stable de compétences et de responsabilités dans tous les CRS.

- La responsabilisation et les rapports quotidiens des CRS envers les collectivités et le ministère de la Santé doivent être clairement définis et acceptés mutuellement.

- Les bénévoles des CRS doivent chercher à atteindre les objectifs de la ***vision de la santé*** et de la réforme du système de santé et leur rôle doit être reconnu et prisé par le ministre et le ministère de la Santé. De plus, afin de pouvoir prodiguer des conseils judicieux, ces bénévoles doivent être appuyés par du personnel compétent et des ressources appropriées.

- Les partenariats conclus entre les intervenants doivent s'appuyer sur des rapports empreints de respect et de confiance, favoriser l'interaction et être évalués de façon continue.

- La participation de tous les partenaires et intervenants du système de santé exige un engagement envers la réforme du système et une gestion efficace des changements et des incertitudes.

- La planification du système de santé exige que des partenariats soient noués aux paliers local, régional et provincial, puis que des processus de planification efficaces soient instaurés à chacun de ces paliers.

Le GTM a élaboré l'infrastructure de planification suivante pour maximiser le potentiel des CRS et du ministère de la Santé en matière de planification du système de santé, sans déborder du cadre des déterminants de la santé.

L'infrastructure de la planification

Les rôles et les responsabilités reliés à la planification

Il existe une interdépendance considérable entre les groupes qui participent au processus d'élaboration de politiques et de planification. Le tableau I illustre l'infrastructure de planification élaborée par le GTM pour préciser les responsabilités des CRS dans le cadre d'un système de santé global.

Cette infrastructure établit les cinq «étapes» reliées à l'élaboration et à la mise en oeuvre de politiques : ***les politiques stratégiques, l'infrastructure de planification, le plan de mise en oeuvre, la planification locale et régionale*** et ***la prestation locale de services.*** À chacune de ces étapes, un des partenaires du processus de planification sort des rangs pour assumer le rôle de «chef de file», encadré et appuyé par tous les autres intervenants participant au processus. Les partenaires assument donc les rôles suivants dans cette infrastructure :

Le ministère de la Santé

- amorce le processus d'élaboration de politiques stratégiques au sein du gouvernement en fonction des besoins relevés par les usagers, les CRS et les prestateurs de services, et

- dirige l'élaboration d'une infrastructure de planification et d'un plan de mise en oeuvre pour chaque politique instaurée.

Les CRS

- font office d'intermédiaire entre les directives et les politiques du ministère et les priorités et les besoins de leurs collectivités respectives, et

- doivent assurer l'intégration des politiques gouvernementales au processus de planification qui se déroule aux paliers local et régional.

Les prestateurs de soins et de services de soutien

- doivent assurer la gestion et la prestation de services efficaces et de qualité élevée, tout en respectant les directives ainsi que les politiques locales et provinciales, en plus des normes de pratique professionnelles, le cas échéant.

Les usagers

- Il va sans dire que le ministère, les CRS et les prestateurs de services sont en fin de compte responsables envers les usagers.

Tableau I : Élaboration de politiques et schéma de mise en oeuvre

PARTENAIRES / ÉTAPES	Gouvernement MDS	Groupe des stratégies de la santé MDS	Activités MDS	CRS	Prestateurs de services
Politiques stratégiques	Dirige	Appuie	Appuie	Appuie	Appuie
Infrastructure de planification	Appuie	Dirige	Appuie	Appuie	Appuie
Plan de mise en oeuvre	Appuie	Appuie	Dirige	Appuie	Appuie
Planification locale et régionale	Appuie	Appuie	Appuie	Dirige	Appuie
Prestation locale de services	Appuie	Appuie	Appuie	Appuie	Dirige

(MDS = ministère de la santé)

Les nouvelles positions des conseils régionaux de santé

Pour que les CRS puissent assumer le rôle de principal organisme de planification dans le cadre du système de santé, ils doivent posséder le pouvoir d'agir dans le cadre des responsabilités qui leur sont conférées. S'ils ne disposent pas de ressources adéquates, les CRS ne seront pas en mesure d'assumer pleinement et efficacement ces responsabilités.

Le GTM a fait ressortir les quatre thèmes principaux suivants, lesquels doivent être abordés afin de préparer et d'encadrer les conseils régionaux de santé en vue des rôles et des responsabilités qu'ils devront assumer à titre de planificateurs de premier plan :

I. Autorité et direction;
II. Responsabilisation;
III. Pouvoir de planification régionale;
IV. Réseaux.

Le GTM a élaboré une série d'orientations stratégiques qui favoriseront la concrétisation de chaque thème. Il a également établi des mesures d'exécution précises ainsi qu'un ensemble de mécanismes

essentiels qui permettront d'assurer la planification de la ***vision de la santé.*** (Ces mesures et mécanismes se retrouvent dans le rapport sur la mise en oeuvre.)

Les thèmes principaux

I. Autorité et direction

Les conseils régionaux de santé, clairement désignés pour diriger la planification du système de santé, se verront conférer le pouvoir d'agir en vertu d'un mandat précisé dans des règlements et des politiques. Cela facilitera et clarifiera les pouvoirs que les CRS se voient demander d'assumer en ce qui touche l'affectation et la réaffectation des ressources dans leur propre district. Les CRS réagiront en perfectionnant et en rehaussant l'engagement et la capacité de leurs bénévoles ainsi que de leur personnel, de façon à s'acquitter efficacement de leur mandat, qui est de soumettre des recommandations judicieuses au ministre de la Santé.

Orientations stratégiques

1. Le rôle de ***principaux organismes de planification*** que les conseils régionaux de santé devront assumer en intégrant les perspectives locales et régionales au système global de santé sera formalisé au moyen de politiques et de règlements.

2. Les conseils régionaux de santé se verront explicitement conférer le pouvoir de conseiller le ministre sur l'affectation et la réaffectation des ressources du système de santé dans leur propre région ou district.

3. Les conseils régionaux de santé conseilleront le ministre sur les décisions qui portent sur les politiques et la planification et qui influent sur la planification locale et régionale des services de santé.

4. Les conseils régionaux de santé peuvent également conseiller le ministre sur l'affectation de ressources au palier provincial.

5. Les conseils régionaux de santé auront en outre le pouvoir de fonctionner de façon autonome dans le cadre de l'infrastructure de responsabilisation établie.

6. Les conseils régionaux de santé rehausseront l'engagement et la capacité de leurs bénévoles ainsi que de leur personnel, pour soumettre des recommandations judicieuses au ministre.

7. Le ministre et le ministère de la Santé appuieront et promouvront immanquablement les rôles des conseils régionaux de santé auprès de tous les intervenants du système de santé.

II. Responsabilisation

Le fait que les CRS soient responsables tant envers les membres de leur collectivité qu'envers le ministre de la Santé exige une certaine latitude dans leur planification de services pour répondre aux besoins locaux, planification qui est effectuée dans le cadre des politiques, des directives et des normes établies à l'échelle provinciale. Pour assurer l'efficacité et la crédibilité de leurs rapports, les CRS et le ministère doivent établir des modes de communication précis entre eux ainsi qu'avec les collectivités locales.

Les processus décisionnels et de planification des CRS et du ministère de la Santé doivent être justifiables auprès du public qu'ils desservent et être dotés de mécanismes d'évaluation solides. Les CRS encourageront la participation des résidents locaux et un apport important de leur part, en veillant à ce que les membres de la collectivité siégeant aux CRS représentent une gamme de compétences, d'expériences et d'intérêts, et en instaurant des mécanismes pour orienter et informer les membres du conseil afin que ces derniers puissent assumer pleinement leurs responsabilités.

Le ministère de la Santé s'efforcera de veiller à ce que les CRS puissent prévoir les ressources financières dont ils disposeront pour leurs activités de planification.

Orientations stratégiques

1. Les conseils régionaux de santé posséderont la souplesse et la latitude requises pour planifier, dans le cadre des politiques, des normes, des directives et des orientations provinciales, les services qui répondront aux priorités et aux besoins locaux.

2. Des voies de communication et de consultation précises seront établies entre le ministère de la Santé et les conseils régionaux de santé, ainsi qu'entre les CRS et les collectivités qu'ils desservent, afin de rehausser l'efficacité et la responsabilité des résultats de leur planification.

3. Les processus décisionnels et de planification des conseils régionaux de santé et du ministère de la Santé s'appuieront sur des mécanismes justifiables et comprendront un élément d'évaluation du processus de planification et des résultats.

4. Les conseils régionaux de santé formeront un noyau de bénévoles et d'employés qui possédera une gamme adéquate de compétences, de connaissances et d'expériences qui leur permettra d'exécuter leurs tâches de planification ainsi que de s'acquitter de leurs rôles et responsabilités actuelles et à venir.

5. Les conseils régionaux de santé élargiront leur représentativité afin de veiller à ce que les bénévoles qui siègent au conseil et aux comités représentent les priorités et les points de vue du grand public.

6. Le ministère de la Santé rehaussera le degré avec lequel les conseils régionaux de santé peuvent prévoir les ressources financières dont ils disposeront pour leurs activités de planification.

III. Pouvoir de planification régionale

Pour bien gérer le système de santé, les CRS doivent participer à chaque étape de l'infrastructure d'élaboration de politiques, au lieu de ne planifier qu'une réforme sectorielle au palier local. Pour réussir, la planification régionale devra aborder tous les secteurs, de façon globale et intégrative. La planification régionale pourrait créer de plus grandes économies d'échelle et rehausser l'équité au sein des régions en assurant la prestation de services qui ne seraient peut-être pas offerts autrement.

Les conseils régionaux de santé joueront un rôle de premier plan en ce qui a trait à la planification régionale des services de santé, en s'appuyant sur leurs forces, leurs rapports et leurs ressources collectives. Pour assumer pleinement leur rôle de planificateurs régionaux, les CRS ont besoin que le ministère leur accorde son appui sous forme de règlements, de politiques et de directives qui faciliteraient l'élaboration de modèles souples dans les six régions de la province. Cela créerait en outre un forum pour les CRS, lequel leur permettrait de discuter et de négocier un partage des

ressources ainsi que les possibilités de rationalisation des opérations et des programmes dans une perspective régionale.

Orientations stratégiques

1. Le ministère de la Santé élaborera une infrastructure précise de règlements et de politiques axée sur les principes de planification relevés et contenant les normes et les directives de planification régionale.

2. Le ministère de la Santé élaborera des politiques et des règlements qui identifieront et autoriseront explicitement les conseils régionaux de santé comme ***principaux planificateurs régionaux*** du système de santé.

3. Les structures de planification régionales miseront sur les forces, les rapports, les ressources et l'expertise collectives des conseils régionaux de santé actuels afin d'éviter d'alourdir l'infrastructure administrative, puis s'adapteront aux régions afin d'assurer la satisfaction des besoins locaux ainsi que le respect des politiques provinciales.

4. Le GTM reconnaît que comme tous les autres volets du système de santé, les conseils régionaux de santé doivent, eux aussi, rationaliser collectivement leurs structures, leurs opérations et leurs prises de décision.

IV. Réseaux

L'adoption de mesures efficaces sur les déterminants de la santé et l'élargissement du sens conféré au terme «santé» exigent que les conseils régionaux de santé instaurent des réseaux de planification locale et régionale des services de santé avec d'autres intervenants. Il faudra inclure les secteurs qui ne sont pas habituellement compris dans le domaine de la santé. Les conseils régionaux de santé peuvent forger des alliances en élaborant et en mettant en oeuvre des stratégies détaillées de communication et de mise en marché qui rejoignent les membres des collectivités desservies. De tels liens doivent également exister avec le ministère, particulièrement lorsqu'il s'agit de l'élaboration de politiques officielles favorisant la santé. Le réseautage est, de par sa nature, bilatéral; les parties qui y participent acceptent de donner et de recevoir des conseils.

Orientations stratégiques

1. Les conseils régionaux de santé forgeront des réseaux local et régional de planification de la santé avec les autres intervenants et partenaires du processus de planification.

2. Le réseautage est un processus réciproque; les conseils régionaux de santé et le ministère de la Santé s'efforceront donc d'accepter de ***donner*** et de ***recevoir*** des conseils et des recommandations.

3. Le ministère de la Santé explorera et définira explicitement les rôles et les responsabilités qu'il assume en matière de planification par rapport aux autres ministères et aux autres secteurs. Il devra plus précisément forger des alliances avec le ministère des Services sociaux et communautaires et avec le ministère de l'Éducation, favorisant l'élaboration en commun de politiques dans les domaines d'intérêts communs.

4. Les conseils régionaux de santé exploreront et formeront des alliances avec les bureaux locaux d'autres ministères afin de planifier et d'échanger de l'information.

5. Les conseils régionaux de santé élaboreront et mettront en oeuvre des stratégies détaillées de communication et de mise en marché qui inciteront leurs collectivités à consolider leurs alliances.

Conclusion

La planification de la santé est l'élément essentiel reliant la ***vision de la santé*** pour toute la population de l'Ontario et les moyens qui permettront de l'atteindre. Le travail accompli et le processus utilisé par ce groupe de travail du ministère de la Santé, du ministère des Services sociaux et communautaires et des conseils régionaux de santé illustrent le désir de remanier le système de santé dans un esprit de partenariat.

Implementation Report

Moving Forward: Strengthening Health Planning In Ontario

Implementation Report

The Need for Action

The Government of Ontario endorses a ***Vision of Health*** that emphasizes a broader definition of "health." The Government believes that to achieve health and well-being we need strategies that focus on the determinants of health and improve the organization and management of the system. The Ministry of Health (MOH) has set out an agenda for reforming Ontario's health system. Under this agenda, strategic health planning will maximize the quality of care and efficiency from the resources that are available. The Minister of Health is inviting District Health Councils, through their planning role, to become partners in reforming the system.

The Mandate of District Health Councils

The origins of District Health Councils in Ontario go back to the early 1970's when they were first established to do local and regional planning. Appendix D provides a historical overview of DHCs. The Ministry of Health's operational guidelines for DHCs from 1974 stated that:

> [District Health] *Councils will be given the responsibility for recommending to the Ministry plans for the delivery of health care in each district...Councils will be advisory bodies and no agency programs will be submitted to the Ministry for approval without prior approval of the District Health Council.*

This is the cornerstone of the DHC mandate. It has remained relatively unchanged since 1973. The original terms of reference give DHCs the responsibility to:

- *identify district health needs and consider alternative methods of meeting those needs that are consistent with provincial guidelines;*

- *plan a comprehensive health care program and establish short-term priorities that are consistent with long-term goals;*

- *coordinate all health activities and ensure balanced, effective and economical service, satisfactory to the people of the district;*

- *work toward co-operation in the social development activities for the district.*

[From *The District Health Council: Action Centre in Ontario's Health Care Delivery*, 1974]

The Minister of Health reinforced and endorsed the scope of the DHCs' planning function in the 1989 report, *District Health Councils: Partners in Health Planning*. This report identified four advisory planning areas in the enhanced roles of DHCs. These roles are:

- allocating funds

- determining human resource requirements in the health field

- strengthening area-wide planning, and

- achieving integration of health and social services planning.

Since the Royal Commission on Health Services first proposed District Health Councils in 1964, the intended responsibilities and functions of DHCs have not changed very much. What ***has*** changed significantly is the context in which DHCs must plan. The provincial Government's current reform strategies — based on the fiscal, social and political realities of the 1990's and beyond — mark the emergence of a transformed health system.

The Impetus for Change

Today, District Health Councils are giving advice to the Government in a different economic climate. It's an economic climate that has shifted the planning focus from one of setting up new and expanded services to restructuring the system and reallocating existing resources.

Although District Health Councils have tried to take action on their original and enhanced roles sufficient attention has not been given to the basic supports they require. These include a need to focus more attention on the resources, policy framework and political mandate for action. DHCs are now experiencing a greater intensity, complexity and level of activity. These require careful review and strengthening of resources and regulatory frameworks.

The economic recession which has continued in Ontario through the early 1990's has greatly increased the need for health system reform. Over the last 30 years there have been various reports and recommendations that have led to reforms. These reforms deal with the very definition of health and the foundations and structure of the health system as we know it.

The current complexity and challenges of Ontario's health system mean that to restructure and achieve a sustainable health system, DHCs and the Government, jointly, must develop their capacity to act as facilitators, adjudicators and advocates in restructuring for a sustainable health system. The Government and DHCs are much readier than previously to proceed with change.

In 1973 there was only one DHC. In 1993, there are 32 DHCs. Two steering committees are considering formation of DHCs. Existing DHCs cover more than 98% of Ontario's population. DHCs have expanded their experience in and ability to take on a greater role in system-wide planning. The Ministry of Health is developing a comprehensive strategic health plan to facilitate reform through the ***Vision of Health*** and the *Goals and Strategic Priorities* (1992) document. The Minister of Health has recognized that the current organization and structure of DHCs can't deal with the greater demands and responsibilities. There is a need for a stronger and coordinated planning infrastructure, appropriate resources, and a mandate clearly supported in policy and regulation.

The Joint Task Force

The Joint Task Force (JTF) is a joint undertaking of the Association of District Health Councils (ADHCO) and the Ministry of Health (MOH) with the participation of the Ministry of Community and Social Services (MCSS). Set up in December 1992, it has a mandate to examine the roles of DHCs in the health system and to determine what is necessary to achieve and support these roles.

The Joint Task Force's terms of reference, membership and the mandate of ADHCO are included as appendices to this report.

Specifically, the JTF was asked to:

- define the practical roles and mandates of DHCs as they relate to health system planning;
- recommend adequate resourcing for these roles and mandates; and
- maximize positive relationships among the partners in health system reform.

In this report, the Joint Task Force has set out to achieve the following goals in addressing the role of District Health Councils in a reformed health system:

- to develop a vision of the future of DHCs in the health system which will frame decisions about roles, responsibilities, relationships, infrastructure and resources;
- to address the planning implications of sectoral reform and define the planning relationship of sectoral reform to the planning for the health system;
- to address the operational issues for DHCs to function more effectively in planning the health system for their communities.

The process that the JTF undertook to formulate this report included the perspectives of every region in the province.

This report represents the strategies and actions that the Joint Task Force recommends to the Minister of Health. The JTF sees these recommendations being implemented over the next three years by the Ministry of Health and District Health Councils (through the auspices of the ADHCO).

The expectation of the Joint Task Force is that this report will form the basis of a policy framework. This policy framework would guide timely and appropriate action by the Government and District Health Councils to further health system planning and reform.

A Note Concerning Devolution

During the JTF's deliberations, Ministry of Health representatives set out the parameters of change within which the roles of DHCs should evolve. These parameters clearly indicated that devolution of management and fiscal authority is not a Government priority in the short or medium-term. Rather, the Ministry has indicated that it expects District Health Councils to assume strengthened planning functions, including the advisory authority to allocate and reallocate designated resources. The Joint Task Force appreciates the need for these clear parameters at this time. However, in order for DHCs to effectively fulfil their responsibilities, they will rely on the Government to discharge its obligations in policy development and fiscal management in a timely and responsible manner.

Our Visions and Values

The JTF members recognize that we can't have a viable, high-quality health system in Ontario without collectively changing the way we do business. The JTF also recognizes that the goals we set today to achieve change will form the basis for tomorrow's health system.

The ***Vision of Health*** sets out what the JTF believes is the primary goal of health system reform. The ***Role of Planning*** explains how the JTF sees achieving the Vision.

The Vision of Health

The Ministry of Health endorses the ***Vision of Health*** that the Premier's Council on Health Strategy developed:

> *We see an Ontario in which people live longer in good health, and disease and disability are progressively reduced. We see people empowered to realize their full health potential through a safe, non-violent environment, adequate income, housing, food and education, and a valued role to play in family, work and the community. We see people having equitable access to affordable and appropriate health care, regardless of geography, income, age, gender or cultural background. Finally, we see everyone working together to achieve better health for all.*

The Joint Task Force adopts this ***Vision of Health***.

The Role of Health Planning

Planning is the link between recognizing the determinants of health and taking action on them to improve the health of everyone who lives in Ontario.

Planning involves developing clear, practical strategies to achieve the goals that the ***Vision of Health*** sets out. In addition, it is essential to get the most from Ontario's health system in terms of care, efficiency and cost-effectiveness.

The Joint Task Force envisions an Ontario where the health of the population is promoted through healthy public policy, a focus on the environmental, economic, social and educational determinants of health, and an appropriately planned and designed health system.

Strong community-focused planning, on a local and regional basis, is essential to facilitate the necessary changes, understandings, consensus-building and resolution of difficult issues, and gives a context to resource allocation and provincial policy development and planning.

The current and continuing need to reform Ontario's health system, in the context of the determinants of health, means that health planning bodies need to have the authority to lead local and regional restructuring, and influence provincial directions.

Achieving the Vision

Achieving the ***Vision of Health*** through planning means satisfying the following conditions:

- There must be effective and meaningful processes that enable communities to achieve optimal health through the availability of high-quality, efficient health services which respond to their needs.

- There must be fostering and respect for the differences and uniqueness of DHCs that reflect the diversity of communities across the province. At the same time, there must be a consistent core of competencies and responsibilities across all DHCs.

- There must be clear definitions and mutual agreement about the day-to-day relationships and accountability that DHCs have to their communities and to the Minister of Health.

- DHC volunteers must have a commitment to the goals of achieving the ***Vision of Health*** and health system reform and have their role recognized and valued by the Minister and Ministry of Health; in order to provide high quality advice, volunteers must be supported by capable staff and adequate resources.

- Partnerships between stakeholders must be built on trusting and respectful relationships, with regular feedback and ongoing evaluation of the relationships.

- A commitment to system reform and effective management of change and uncertainty must be prerequisites of participation by all partners and stakeholders in the health system.

- Partnerships at the local, regional and provincial level, plus effective planning processes at each level are necessary to planning for the health system.

The JTF does not propose fundamental changes in the mandate given to DHCs in 1974. It ***does*** recognize that today's health system and the environment in which planning must occur are much more complex than in 1974. This makes satisfying the above conditions even more central to effective planning.

The JTF has developed the following planning framework. It will guide DHCs and the Ministry of Health in achieving their full potential in health system planning within a ***determinants of health*** framework.

The Planning Framework

The Joint Task Force recognizes that District Health Councils are a vital part of effective health system planning and leaders in the reform process.

DHCs:

- are the designated health system planning advisors to the Minister of Health;

- as volunteer and locally-based organizations, draw upon local values in the planning process;

- are neutral brokers that respond to the needs of their communities in a manner consistent with and supportive of provincial policy frameworks.

These particular strengths of DHCs are the basis for building a reformed health system and giving DHCs a strong and clear direction and a mandate for leadership in health and health system planning.

With suitable restructuring and resourcing, we see DHCs taking on this challenge and leading the planning process for achieving Ontario's health goals. To accomplish this challenge, the Joint Task Force and DHCs will need the continuing support of the Government, as well as care and support providers, and consumers. To achieve the ***Vision of Health***, partnerships, the range of relationships, and the scope and functions of planning and decision-making must change.

The JTF has developed a framework or "road-map" to clarify the responsibilities of DHCs within the broader health system. The intention of this framework is to achieve the following explicit objectives:

- to define the planning roles and responsibilities of the Ministry of Health, District Health Councils and, in long term care, the Ministry of Community and Social Services, as they relate to health system reforms, and

- to position DHCs to meet planning expectations emerging from the reform of Ontario's health system.

At the present time, DHCs are responsible for local and regional planning. Some DHC activities also require province-wide collaboration. There is a need to formalize and clearly specify accountability for both the roles that DHCs currently perform and the new ones that the Government is asking them to take on, like sectoral reform.

Planning Principles

Explicit principles that guide and inform the process are the basis of an effective planning framework. They also provide a consistent basis for planning across the province and across sectors. The JTF endorses the following principles:

- The ***Vision of Health*** is the foundation for health planning. The Ministry of Health's current and future policy and fiscal frameworks guide the objectives and process of planning.

- Planning decisions are made at the level closest and most appropriate to where those decisions have greatest impact.

- Planning facilitates the equity of access of stakeholders from all levels, particularly local communities, including consumers and care and support providers, through open, supportive and collaborative partnerships.

- Planning includes ongoing evaluation and monitoring of the process and the outcomes of that process.

- Planning occurs with recognition of the Government's finite fiscal framework, and links expenditures to outcomes wherever possible. Planning also incorporates an obligation to responsibly determine the allocation and reallocation of available resources.

- Planning is informed by and incorporates:
  - population needs
  - quality management approaches
  - accurate and timely qualitative and quantitative data and information
  - research-based practices demonstrating effective outcomes.

Planning Roles and Responsibilities

The Minister of Health has designated District Health Councils as the lead health planning authorities at the local and regional level. The Ministry takes the lead provincially. As planning partners, DHCs and the Ministry will share responsibilities through collaborative and strategic planning for the health of the population and the operation of the health system.

Table I sets out the preferred policy development and implementation framework for health planning. It shows how much interdependence there is among the groups and the parts of the policy and planning process.

The framework sets out the five "what's" of policy development and implementation — ***strategic policy, planning framework, implementation plan, local/regional planning and local service delivery***. At each stage, there is a designated "lead" from among the planning partners, with the planning partners all participating and providing support and input.

As the planning framework indicates:

The Ministry of Health

- starts the process of strategic policy development within Government, based on the needs that consumers, DHCs and care and support providers identify, and

- leads the development of a planning framework and implementation plan for each identified policy initiative.

DHCs

- are the interface between the Ministry's policy and guidelines and the priorities and needs of their local communities, and

- are responsible for incorporating Government policies into the planning process at the local and regional levels.

Care and Support Providers

- are responsible for managing and delivering high quality and efficient services, based on provincial and local policies and guidelines and, where applicable, professional standards of practice.

Consumers

- The Ministry, DHCs and care and support providers are, of course, ultimately accountable to consumers.

Table I: Policy Development and Implementation Framework

WHAT \ WHO	Government MOH	Health Strategies Group MOH	Operations MOH	DHCs	Providers
Strategic Policy	Lead	Support	Support	Support	Support
Planning Framework	Support	Lead	Support	Support	Support
Implementation Plan	Support	Support	Lead	Support	Support
Local/Regional Planning	Support	Support	Support	Lead	Support
Local Service Delivery	Support	Support	Support	Support	Lead

The conclusions of the JTF on the appropriate roles and responsibilities of the MOH and DHCs are outlined below. These conclusions are drawn mainly from the many recommendations found in previous planning reports and statements from the Ministry of Health.

The Ministry of Health

The MOH has the lead role in planning for the following areas:

- establishing the basic objectives and direction of Ontario's health system, including guidelines and standards for planning, management and delivery of services;

- developing policies for health, internally and in coordination with other ministries and the federal Government, where appropriate;

- establishing planning frameworks for each of the policy initiatives identified, with the support of DHCs and other stakeholders as appropriate, and clearly identifying

the responsibilities of involved stakeholders in the planning and implementation of policies;

- collecting, compiling, analyzing and disseminating data and other information which will guide the planning process;

- developing ongoing monitoring and evaluation mechanisms to ensure goals are met within the established standards and guidelines;

- identifying fiscal parameters within which policy and planning can be implemented;

- providing or ensuring the provision of services which must be planned at the provincial level, such as administration of the Ontario Health Insurance Plan, some tertiary care services, or provincial laboratory services;

- ensuring efficient and effective processes exist to address immediate and urgent issues which may arise apart from the strategic and comprehensive planning process.

District Health Councils

The planning function of DHCs requires DHCs to:

- take the lead in district-level strategic planning for health services and programs which reflect local needs and priorities and are informed by Government objectives, policies and fiscal parameters;

- plan for a comprehensive health system through the coordination and integration of existing and potential programs and services;

- promote and support action on the determinants of health at the local level;

- establish program and/or service planning objectives based on identified needs and local priorities, investigating ways of achieving objectives and recommending priorities as to how existing needs could best be met;

- plan for and be catalysts in health system change;

- plan and make recommendations to the Minister in the following areas:

  - allocation and/or reallocation of health system resources to achieve local and provincial strategic objectives;

  - health human resource requirements for services provided in individual districts to adequately meet identified needs;

  - appropriate means for integration of social services which interact with health services and needs in the district;

- coordinate and collaborate with other districts within and between respective regions for effective and efficient regional and provincial health system planning;

- participate in collecting, analyzing, utilizing and disseminating data and information relevant to health status, population needs and health planning;

- develop evaluation and ongoing monitoring mechanisms for programs and services in the district to ensure goals and objectives are met within established standards and guidelines;

- involve consumers and care and support providers in the planning process, and provide their feedback on health policies and programs to the Minister;

- develop appropriate linkages with other local planning agencies as appropriate.

Repositioning District Health Councils

For DHCs to function in the health system as lead planning bodies, they must have the capacity to deliver on their responsibilities. Without adequate resources, DHCs won't be able to meet their responsibilities effectively or efficiently.

The JTF has identified four central themes that must be addressed to prepare and support District Health Councils to accomplish their roles and responsibilities as designated lead planners. These are:

I. Authority and Leadership
II. Accountability
III. Regional Planning Capacity
IV. Linkages.

The JTF has set out a series of strategic directions that will support the achievement of each theme. It has also developed specific strategies for action and a set of necessary enabling mechanisms to achieve the ***Vision of Health Planning***.

Central Themes for Achieving the Visions

I. Authority and Leadership

Individually and collectively, Government, consumers, care and support providers and other stakeholders have all recognized and supported the need for basic health system reform. Comprehensive health system planning is an essential part of effective system management and change. The Minister of Health has designated DHCs as partners and lead planners for health system reform, recognizing the experience and expertise which they have gained over the last 20 years.

As designated ***leaders*** of local and regional health planning, DHCs must provide ***leadership*** — through commitment and capability — to bring together and empower their communities and other stakeholders in the system. DHC leadership includes several roles: facilitation, advocacy, mediation and negotiation for their communities.

DHCs' authority to lead planning depends on two conditions:

- the Minister clearly setting out and delegating DHC responsibilities, and

- the capacity of DHCs to deliver on their obligations. This capacity depends significantly on there being an independent operating relationship with the Ministry of Health that gives DHCs the discretion to make more effective use of their volunteer and staff strengths.

Strategic Directions to Support DHCs' Authority and Leadership

1. The role of District Health Councils as the ***lead planning bodies***, responsible for planning a comprehensive health system, from both local and regional perspectives will be formalized through regulation and policy.

2. District Health Councils will be explicitly delegated the authority to advise the Minister about the allocation and reallocation of health system resources within their districts or regions.

3. DHCs will provide advice to the Minister regarding planning and policy decisions which affect local and regional health planning.

4. DHCs may also provide advice to the Minister regarding the allocation of resources at a provincial level.

5. District Health Councils will be empowered to operate at arm's length within the established accountability framework.

6. District Health Councils will further develop the commitment and capacity of their volunteers and staff to provide high-quality and sound advice to the Minister.

7. The Minister and Ministry of Health will consistently support and promote the roles of District Health Councils to all stakeholders in the health system.

II. Accountability

District Health Councils have the responsibility to plan effectively for the health needs of their communities. They must, of course, carry out this responsibility within the standards and guidelines that the Government sets. This means that DHCs must recognize their local, regional and provincial obligations.

DHCs are primarily accountable to the Minister of Health to:

- plan effectively for the health system, and
- to provide sound advice to the Minister on the allocation and reallocation of resources.

DHCs must measure and evaluate the impact of allocating or reallocating resources between programs and sectors within health. This ensures that the needs of individuals and communities are met efficiently, appropriately and effectively.

In order to fulfil their responsibilities to the Minister, DHCs must also be accountable to their communities to determine local needs and priorities, to do this accurately and effectively, and to plan for the best way to meet those needs.

DHCs demonstrate their responsibility to their communities through their local, volunteer-based membership. These volunteers reflect the views of consumers, care and support providers, and municipal Governments.

Ultimately, it is DHCs' accountability to their communities that enables them to achieve accountability to the Minister.

Strategic Directions to Support DHCs' Accountability

1. District Health Councils will have the flexibility and latitude to plan for local needs and priorities within the framework of provincial policies, standards, guidelines and directions.

2. Clear channels of communication will be developed between the Ministry of Health and District Health Councils, and District Health Councils and their communities to enhance the effectiveness, accountability and ownership of DHC planning outcomes.

3. The planning and decision-making of DHCs and the MOH will be based on defensible processes. Both the planning process and the outcomes will incorporate an evaluation component.

4. District Health Councils will build a core of staff and volunteers. Volunteers and staff will have an appropriate mix of skills, knowledge and experience to address the planning agenda and to enable DHCs to fulfil their present and evolving roles and responsibilities.

5. DHCs will broaden their membership to ensure that volunteers of Councils and their committees reflect the priorities and perspectives of the community at large.

6. The MOH will develop a budgetary framework to support DHC functions that will allow for greater latitude in DHC operating and planning activities.

III. Regional Planning Capacity

The JTF believes that co-operative and collaborative regional planning between and among DHCs is essential to achieve health system reforms. The capacity for DHCs to plan for the health system from a regional perspective is essential to complete the provincial planning framework.

Regional planning provides a way to take local needs and characteristics into account. This includes factors like demographics and health status. It includes planning for services or programs for more than one DHC and dealing with issues that go beyond geographic and sectoral boundaries.

Sectoral health planning activities have a program focus. Because of this, there is a need for processes that provide coordination and integration across individual sectors. System-wide planning that occurs at the regional and local level cuts down the fragmentation of services between programs and sectors. It thus serves the public more effectively.

Regional planning is not a new role for DHCs. However, the situation in which regional planning must take place is very different today. Regional issues have an unprecedented urgency and complexity, especially in the context of system reform and rationalization. There is a need to develop formal regional networks that take into account the need for comprehensive regional planning. These networks will increase the collaboration and cooperation that occurs among DHCs. They will also improve the integration and coordination between services and programs.

Regional planning has the potential to build on the relationships that already exist among DHCs. It will:

- make it possible to achieve more efficiency and effectiveness through economies of scale, and

- facilitate access to services and programs that might not otherwise be available at the local level.

Thus, it helps bring more equity between areas and across regions.

The Planning Framework sets out explicit principles. They will guide and direct both broader system planning and regional planning.

Guidelines for Regional Planning

The JTF believes that the following three guidelines should direct regional planning:

- Regional planning should be driven by and relevant to local community needs. It should respect and reflect local community priorities as well as provincial or regional priorities.

- Regional planning should simplify and streamline the planning process by pooling resources and reducing duplication of effort.

- Regional planning networks should avoid the creation of an additional layer of hierarchy between local communities and the Minister of Health.

Strategic Directions to Support DHCs' Regional Planning Capacity

1. The Ministry of Health will develop a clear policy and regulatory framework. It will be based on identified planning principles which contain standards and guidelines for regional planning.

2. The Ministry of Health will develop policy and regulations that explicitly identify and authorize District Health Councils to be the ***principal regional planners*** for the health system.

3. Regional planning structures will build on the collective strengths, relationships, resources and expertise of existing DHCs. This will avoid the creation of an added layer of bureaucracy. Planning structures will be flexible across regions to ensure that DHCs are responsive to local needs and to provincial policies.

4. The JTF recognizes that DHCs must collectively rationalize their structures, operations and decision-making, just as other parts of the health system do.

IV. Linkages

The ***Vision of Health*** and the determinants of health underline how important it is to be aware of, understand, and recognize that there are interdependencies and relationships between and among many fields and disciplines. This includes areas like education and housing, and parts of the health system itself. There is a need to advocate on behalf of these links, and to strengthen and formalize them. This is especially true when it comes to the link between the Ministry of Health and other human service ministries, such as Community and Social Services, Housing, and Education.

An excellent example of existing linkages is the cooperative and collaborative effort between the Ministry of Health and the Ministry of Community and Social Services in their development of long-term care policy.

DHCs can be strong advocates and supporters of the determinants of health at the local level by encouraging links between health and other human services.

A needs-based approach to planning recognizes the value of effective communication with local communities. This provides a reliable way to decide on needs and priorities. Effective and enduring planning strategies that can be implemented successfully require strong linkages if they are to get the input and support of local communities and care and support providers. DHCs are in a position to be catalysts in facilitating linkages between stakeholders in their local communities.

Finally, cooperative and collaborative relationships allow greater opportunities for sharing information and ideas and for exploring and pursuing shared goals.

Strategic Directions to Support Linkages

1. District Health Councils will actively develop local and regional health planning networks with other stakeholders and partners in the planning process.

2. Linkages are two-way. Therefore, DHCs and the MOH will endeavour to be open to both ***giving*** and ***receiving*** advice and direction.

3. Where appropriate, the Ministry of Health will explore and explicitly identify the planning roles and responsibilities the Ministry has with other Ministries and sectors. In particular, the MOH will develop linkages for joint policy development with the Ministry of Community and Social Services and the Ministry of Education in areas of common interest.

4. District Health Councils will explore and develop planning and information-sharing linkages with local offices of other ministries.

5. District Health Councils will develop and implement comprehensive communications and marketing strategies which will actively reach out to their communities to forge stronger links.

Strategies for Action and Enabling Mechanisms

This section of the report sets out the specific Strategies For Action and Enabling Mechanisms that the JTF considers are necessary to strengthen health planning in Ontario and to facilitate implementation of the Strategic Directions.

This comprehensive set of strategies and mechanisms must be acted on, as a whole, to move forward with the ***Vision of Health*** through effective health planning.

Effective action on this report requires the continued partnership and commitment of the Ministry of Health, the Ministry of Community and Social Services and District Health Councils.

The Association of District Health Councils of Ontario will review the progress of the implementation of this report in a series of "Report Cards." The first Report Card will be completed in January, 1994. Appendix C sets out the implementation timeline for the strategic actions and enabling mechanisms.

I. Authority and Leadership— Strategies for Action and Enabling Mechanisms

Regulations

I.1 The Government will proceed as soon as possible to enact new regulations or modify existing regulations under the *Ministry of Health Act* (R.S.O. 1990). The new or modified regulations will clearly identify DHCs as designated lead health planners and explicitly specify the structure, functions and responsibilities which result from this role.

Enabling Mechanisms

I.1.i Regulation 656 under the *Ministry of Health Act*, which requires the approval of the Minister for any planning activity by DHCs, will be amended.

I.1.ii By November 1993 a special committee of the MOH and ADHCO will complete the drafting of regulations to address planning roles and responsibilities.

Other Regulatory Supports

I.2 The Government will investigate and initiate other regulatory planning supports in other key health legislation, including legislation relating to long-term care and mental health.

Enabling Mechanism

I.2.i The MOH Legal Services Branch will investigate other legislation for inclusion of DHC health planning responsibilities.

Memorandum of Understanding

I.3 In accordance with Management Board policy for all Schedule III agencies of the Government, the MOH and DHCs will conjointly draft a Memorandum of Understanding (MOU). It will address the accountability relationship between the two parties, the roles and responsibilities of each party, and the legal liability of DHCs and their volunteers and staff.

Enabling Mechanism

I.3.i The Ministry, in conjunction with ADHCO, will complete a final draft of the MOU and an accompanying discussion paper by October 1993.

Policy

I.4 The MOH will help position DHCs to meet evolving expectations related to the reform of Ontario's health system. It will do this by describing in Government policy statements the lead planning role of DHCs and strongly supporting their authority.

Enabling Mechanisms

I.4.i All future health system planning policies from the Ministry of Health in which DHCs are involved will specifically address DHC roles and responsibilities.

I.4.ii The Minister of Health will include references to DHCs in news releases when announcing Ministry actions or decisions which are based on advice received from DHCs.

Planning Frameworks

I.5 Specific planning frameworks for MOH sectoral reforms, such as long-term care, will be developed. They will build on the *Health Services Planning Framework: A Tool for Planning* (January 1992) to include local, regional and provincial planning.

Enabling Mechanisms

I.5.i The Provincial Planning Unit of Information, Planning and Evaluation Branch will develop planning frameworks which explicitly identify the respective roles and responsibilities of all those involved at each level of the planning process.

I.5.ii Operational branches in the Ministry of Health will actively involve DHCs in planning issues for services, populations, and agencies and/or institutions in their districts. They will consult with DHCs prior to making program funding decisions.

Response Protocols

I.6 The Ministry will give DHCs explicit and comprehensive rationales if their advice or recommendations are not acted upon.

I.7 District Health Councils will plan and operate within provincial policies, standards and guidelines. When DHCs advise or plan in a way which is inconsistent with provincial directions, they must provide justifications with explicit and comprehensive rationales.

Enabling Mechanism

I.6.i and I.7.i By Fall 1993, MOH and ADHCO will formalize and complete the collaborative development of protocols for requesting, submitting, accepting and rejecting advice in the form of timely mutual response mechanisms between DHCs and MOH.

DHC Volunteer and Staff Ability and Expertise

I.8 District Health Councils will develop and ensure high standards of ability and expertise for their volunteers and staff in order to provide the Ministry with appropriate and sound planning advice and to improve the leadership capacity of DHCs.

Enabling Mechanisms

I.8.i ADHCO will develop an orientation and continuing education strategy that DHCs will use to actively facilitate the development of volunteers' skills in addressing the issues of health system reforms. ADHCO will announce and initiate this program in the Fall of 1993.

I.8.ii ADHCO will develop a continuing education program that DHCs can use to actively facilitate the development of the skills of staff members in health system planning and reform. This program will be initiated in the Fall of 1993.

I.8.iii The past experiences and knowledge of volunteers will be an integral component in the selection and appointment process of District Health Council members to ensure diverse and equitable reflection of the community composition.

I.8.iv DHCs and the MOH will seek out innovative ideas and solutions in their respective organizations and communities which confront the current challenges in the health system.

II. Accountability— Strategies for Action and Enabling Mechanisms

Communication Mechanisms

II.1 The Ministry of Health, DHCs and communities will develop clear communication mechanisms to ensure that they are able to respond and communicate with each other in a timely manner.

Enabling Mechanisms

II.1.i Communications channels will be straightforward and rapid to ensure partners are able to respond to each other in a timely manner. The standard turnaround time for responses will be eight weeks unless the partners mutually agree to another schedule.

II.1.ii In certain circumstances, a quick response mechanism which is mutually agreeable will be necessary to meet local or provincial needs. By Fall 1993, ADHCO and IPEB will develop a quick response mechanism.

II.1.iii By December 1993, MOH and ADHCO's Communication and Marketing Committee will develop uniform and comprehensive communication mechanisms between DHCs and the MOH to enhance awareness of each other's activities and to convey information that is of mutual interest.

II.1.iv On a timely basis, all branches in the Ministry of Health will communicate to DHCs relevant information pertaining to local or regional health issues.

II.1.v By October 1993, an ADHCO/IPEB team will update operational process requirements as described in the DHC Administration Manual to support DHC planning and operational activities.

II.1.vi By July 1993 IPEB will complete guidelines describing how DHCs may access MOH expertise and information.

II.1.vii Beginning in Fall 1993, community awareness and understanding of the role and mandate of DHCs will be promoted in a process currently being developed by the ADHCO Communication and Marketing Committee.

II.1.viii All DHCs will stimulate input and participation from a broad range of stakeholders and develop mechanisms to communicate planning outcomes. Mechanisms they will use include public forums, annual meetings and reports, and open meetings.

II.1.ix To ensure the accountability of DHCs to their communities DHCs will, through ADHCO's Membership Committee, develop mechanisms to ensure community access to DHC processes and information.

Incentive for Local Reallocation

II.2 DHCs will have the flexibility to respond to local community needs and priorities through the allocation/reallocation of district and/or regional resources.

Enabling Mechanisms

II.2.i DHCs will negotiate with the MOH a mechanism that will provide a means for communities to keep, as an incentive, a substantial proportion of the savings achieved from reallocation activities. These savings will be redirected into local priorities.

II.2.ii A special committee of the MOH and DHCs will be struck to set standards and guidelines for making allocation and reallocation decisions. The guidelines will decide on the parameters of action within the following range:

- independent local decision-making, with MOH input as appropriate
- negotiated decision-making between the Ministry and DHCs
- independent provincial decision-making, with DHC input as appropriate.

II.2.iii DHCs' responsibilities for allocating and reallocating resources open up the possibility of greater potential for controversy. Therefore, by Fall 1993, the special committee of ADHCO and MOH will review and update conflict of interest guidelines for volunteers and staff.

Operational Flexibility: Budget Process

II.3 District Health Councils will be funded to permit expenditures within core allocated budgets that allow for discretionary spending within the core budget. The global budgets will reflect more realistically the resources that DHCs need for day-to-day functions and responsibilities.

Enabling Mechanisms

II.3.i By June 1993, ADHCO and IPEB will define and implement the components of a core allocated budget to provide all DHCs with standard limits within which they can negotiate their annual budget letters.

II.3.ii Each DHC will develop clear mechanisms to set priorities and rationalize its volume of work to ensure effective use of the limited resources available in the system.

II.3.iii DHCs will develop specific operational plans which outline goals and priorities on an annual basis. It will make these available to both the Ministry and the community.

Resources

II.4 District Health Councils will have appropriate resources to implement the MOH's strategic directions, priorities and sectoral reforms.

Enabling Mechanisms

II.4.i During the 1993-94 fiscal year, an ADHCO/IPEB team will complete a comprehensive assessment of current and anticipated resource requirements for DHCs. This will identify appropriate resourcing for DHCs to provide leadership in sectoral reforms and regional planning.

II.4.ii ADHCO and IPEB will re-examine and define special projects to ensure that DHCs do not have to depend on special funding to maintain core activities.

Appointments Process

II.5 DHCs and the Ministry of Health will develop a streamlined and effective appointments process for DHCs. Its purpose will be to assist DHCs in maintaining full volunteer membership, and to seek assurance that Councils reflect the necessary skills, experience and characteristics of the community.

Enabling Mechanisms

II.5.i By July 1993 the ADHCO/MOH Membership Committee will develop guidelines that incorporate the required knowledge, experience and community perspectives for recruiting and appointing volunteers.

II.5.ii By August 1993, the ADHCO/MOH Membership Committee will complete and DHCs will approve the nomination and appointment protocol guidelines being developed.

Governance

II.6 DHCs will explore and define their governance model. The model will describe the explicit governing responsibilities that Councils have and support the unique accountability that DHCs have to the Minister and to their communities.

Enabling Mechanisms

II.6.i The ADHCO Total Quality Management Committee will develop and propose guidelines that differentiate the governing responsibilities (e.g., for strategic direction setting) that DHCs have and the management responsibilities of Council staff (e.g., for carrying out Council's directions in a timely and efficient manner). The guidelines will be available for discussion and consultation in Fall 1993.

II.6.ii By Fall 1993, ADHCO will update and formalize the generic set of responsibilities and expectations clarifying local, regional and provincial roles for council members, executive directors, planners and other staff.

II.6.iii During 1993-94, ADHCO and DHCs will develop a recommended comprehensive core curriculum for staff orientation and continuing education.

Evaluation Mechanism

II.7 To facilitate the credibility and accountability of DHCs to their partners and the public, DHCs must ensure quality and integrity through an evaluation mechanism.

Enabling Mechanism

II.7.i During 1993 ADHCO will conduct a feasibility study of accreditation approaches.

III. Regional Planning Capacity— Strategies for Action and Enabling Mechanisms

Regulation

III.1 The MOH will ensure that the regional planning mandate of DHCs is explicitly identified in amended or new regulations under the *Ministry of Health Act* and other legislation that is relevant to the authoritative planning functions of DHCs.

Enabling Mechanism

III.1.i The Ministry of Health will complete its drafting of regulations to address regional planning roles and responsibilities by Fall 1993.

Policy

III.2 Through policies and public statements, the Minister of Health will clearly identify DHCs as the lead regional planners, making it clear to all involved stakeholders that DHCs are ultimately accountable for the regional planning process.

Enabling Mechanism

III.2.i There will be formalization of accountability linkages in regional planning between DHCs and key stakeholders, including academic health science centres and provincial foundations such as the Ontario Cancer and Treatment Research Foundation, the Addiction Research Foundation and the Ontario Mental Health Association.

DHC Involvement In Planning

III.3 DHCs will be involved in all components of the planning process, from the initial steps of regional or sectoral policy development to its implementation and evaluation.

Enabling Mechanisms

III.3.i The MOH and DHCs will facilitate this by developing communication linkages between the MOH and DHCs and will build on the expertise of both partners.

Regional Capacity

III.4 The Ministry of Health will assist in building and supporting the capacity of DHCs to undertake regional planning with the necessary resources, including information, staff, and infrastructure.

Enabling Mechanisms

III.4.i The MOH and DHCs will endorse the basic resource elements of a regional planning infrastructure. This will include epidemiological and economic expertise, demographic and other data, human and physical infrastructures.

III.4.ii The MOH and DHCs will jointly explore issues and needs to determine additional resourcing that is necessary for regional planning.

Flexibility

III.5 Each individual region will have the flexibility to adapt the regional planning principles into a model which respects and reflects the needs and priorities of the local communities and programs that are involved.

Enabling Mechanisms

III.5.i The Regional Planning Steering Committee (RPSC), will develop and pilot a regional planning model for the Southwest region of the province. The RPSC will report to the Minister by Fall 1993.

III.5.ii As part of the plan for implementing its proposed regional planning model, the RPSC will review the extent to which the model can be applied in other regions of the province.

Economies of Scale

III.6 DHCs will use the regional planning capacity for responsible use of their available resources, including staff, information and funds.

Enabling Mechanism

III.6.i The Regional Planning Steering Committee will explore and make recommendations about opportunities for DHCs to share resources in a given region.

IV. Linkages— Strategies for Action and Enabling Mechanisms

Public Participation

IV.1 District Health Councils will develop strategies to assure and enhance public participation in all parts of the planning process, including identifying needs and setting priorities.

Enabling Mechanism

IV.1.i DHCs will develop strategies to facilitate the participation of their local communities to actively involve volunteers from the local area.

Care and Support Provider Participation

IV.2 DHCs will provide a forum to enable the development of linkages with and between other health system stakeholders.

Enabling Mechanisms

IV.2.i Interdependence between DHCs and care and support provider groups requires regular consultation with and the inclusion of these groups if there is to be effective and meaningful health system planning.

IV.2.ii Responsibility for health human resources planning requires strong links with post-secondary health education institutions.

IV.2.iii DHCs will actively seek out linkages with the public health units for their districts.

Ministry of Community and Social Services

IV.3 The Ministry of Health will continue to explore ways that it can improve links with the Ministry of Community and Social Services. It will also consider the interdependence of the two ministries as it relates to policy design, community planning and service delivery.

Enabling Mechanism

IV.3.i The MOH will collaboratively develop a planning framework with MCSS to address areas of mutual interest in the planning and delivery of related health and social services.

Determinants of Health

IV.4 DHCs will develop linkages with stakeholders outside the traditional health sector, in order to address and incorporate the determinants of health in the planning process.

Enabling Mechanisms

IV.4.i As appropriate, individual DHCs will actively seek linkages with other local organizations such as Social Planning Councils, schools, child welfare agencies, municipal government agencies, labour groups, and special interest groups.

IV.4.ii ADHCO will develop linkages at the provincial level with other provincial advisory councils and committees, such as the Premier's Council on Health, Well-Being and Social Justice.

Evaluation

IV.5 District Health Councils will develop linkages with research and academic organizations and will draw upon and disseminate their expertise.

Enabling Mechanism

IV.5.i DHCs will initiate linkages with research and academic organizations, including health science centres in their regions or areas to obtain information for the evaluation component of planning.

Summary

The need for direct and timely action on health system reform has never been as evident and urgent as it is today. DHCs and Government alike have demonstrated their readiness and willingness for change.

The Government has endorsed a new ***Vision of Health*** and Health Goals for the province. The Ministry of Health is taking action on reform based on its Goals and Strategic Priorities. The District Health Council system has acquired almost twenty years of experience through which DHCs have developed the capability to take on a leadership role in health system planning. In a joint venture, DHCs and the Ministry of Health with participation from the Ministry of Community and Social Services have embarked upon an examination of the roles and planning responsibilities of DHCs in the health system. The Joint Task Force has recognized that there must be strong commitment for change from all partners in the process if District Health Councils are to fulfil their responsibilities as leaders in health system planning and reform.

This report is the first step in that partnership. It reflects the commitment to and desire for change by representatives from the Ministry of Health, the Ministry of Community and Social Services and District Health Councils.

In fulfilling its mandate, the JTF has proposed four central themes: ***authority and leadership, accountability, regional planning capacity*** and ***linkages***. These four themes define the roles of DHCs and the Ministry of Health in the planning process and determine the resources that Councils need to carry out their functions effectively.

Central Themes

I. Authority and Leadership

District Health Councils, as clearly designated leaders for health system planning, will be given the authority to act at arm's length from the Ministry of Health. This mandate will be clearly supported in regulation and policy. This will facilitate and clarify the authority DHCs are being asked to take on in allocating and re-allocating resources within their local districts. Councils will respond by further developing and refining the commitment and capacity of their volunteers and staff to effectively fulfil their mandates.

II. Accountability

District Health Councils are primarily accountable to the Minister of Health for planning for the ***Vision of Health*** and the health system and for providing sound advice on the allocation and reallocation of resources. DHCs achieve this accountability to the Minister by being accountable to their communities. To be accountable to their communities, DHCs need to have the freedom to plan for local needs within, of course, the policies, guidelines and standards that the provincial government sets. In order to function credibly and effectively, DHCs and the Ministry must ensure that there are clear channels of communication between themselves and with local communities.

The planning and decision-making processes of DHCs and the MOH must be defensible to the public they serve. They must also have strong, "built-in", evaluation components. DHCs will facilitate active local input and participation through their broad community membership that reflects a diversity of skills, experiences and interests. District Health Councils will develop and implement enabling mechanisms to orient and educate volunteers in fulfilling their responsibilities as Council members.

The Ministry of Health will support DHC functions through budgetary frameworks that allow for greater latitude in DHC operating and planning activities.

III. Regional Planning Capacity

District Health Councils will be the principal instruments for regional health planning, building on their collective strengths, relationships and resources. In order to be effective regional planners, DHCs require support from the Ministry in the form of enabling regulations, policies and guidelines which facilitate the development of flexible models across the six provincial regions.

Regional models also create a forum for DHCs to discuss and negotiate the sharing of resources and the possible rationalization of operations and programs to a regional focus.

Regional planning has the potential to create greater economies of scale. It may also result in greater equity across regions by making services available which may otherwise not have been possible. To be system planners, DHCs must be involved from the initial steps of the Policy Development Framework as opposed to planning only for sectoral reform. Examples of this type of DHC involvement include the *Independent Health Facilities Act* and long-term care. Successful undertaking of regional planning will ensure that all sectors are addressed in a comprehensive and integrative manner.

IV. Linkages

Effective action on the determinants of health and a broader definition of health requires District Health Councils to actively develop local and regional health planning networks. These networks will include care and support providers and other stakeholders. This includes stakeholders in sectors that are not traditionally considered "health."

District Health Councils can forge linkages by developing and implementing comprehensive communications and marketing strategies which reach out to their communities. Such linkages must also occur at the Ministry level, particularly in the development of healthy public policy. Linkages are, by nature, two-way in that partners are open to giving and receiving advice.

Health planning is the necessary link between the ***Vision of Health*** for all Ontarians and the means by which it can be achieved. The work and process of this Task Force of the Ministry of Health, the Ministry of Community and Social Services and District Health Councils demonstrates the readiness to proceed in partnership towards health system reform.

Abbreviations and Definitions

For the purposes of this report, the JTF has used the following abbreviations and definitions.

Abbreviations

ADHCO	Association of District Health Councils of Ontario
DHC	District Health Council
IPEB	Information, Planning and Evaluation Branch (Ministry of Health)
JTF	Joint Task Force
MCSS	Ministry of Community and Social Services
MOE	Ministry of Education
MOH	Ministry of Health
MOU	Memorandum of Understanding
RPSC	Regional Planning Steering Committee

Definitions

Accountable — answerable, responsible; requires a clear relationship to be defined between the party which is accountable and the party to which the accountability lies, i.e., accountable *for* something, ***to*** someone.

Authority — official, formal and explicit mandate for specific action(s); in the case of DHCs, their authority arises from legislation in the *Ministry of Health Act.*

Community — a body of people sharing some common element or similarity, such as living in the same place under the same laws; a community may have other common characteristics linking it together, such as culture, language, religion, age, sexual orientation.

Consumers — includes members of the general public, consumer groups, community action groups, labour and of business and industry who do not receive any income from the health care system and are not directly or indirectly involved in the management or delivery of health care services.

> ***Definition Proposed by ADHCO Membership Committee 1993***
> In general, a consumer may be defined as *...an individual who may receive or is receiving health services. While all people at various times consume health services, a consumer,*

as the term is used in health...programs is usually any member of the general public who is not a provider. This implies that a "consumer" does not directly or indirectly earn her/his living (or a significant amount of income) from the provision of health or health-related services.

Determinants of health — factors affecting the health status of individuals, which include biological endowment (such as hereditary disorders); physical environment (such as pollution, adequate housing); social environment (such as family relationships and social supports, employment status and income level); individual behaviour (lifestyle factors such as diet, exercise and smoking); health care (such as vaccinations, physicians' services).

Devolution — the transfer of powers and functions to a semi-autonomous, sub-national political authority which has clear legal status, recognized geographical boundaries, specific functions to perform and statutory authority to raise revenue and make expenditures.

District — the geographic area contained by the boundaries of each DHC.

Goals — indicate the desired outcomes towards which actions/strategies are directed.

Healthy public policy — policies which encourage and support governmental, community and individual endeavours to improve health, in areas such as economic development, community development, advocacy, technology development and dissemination, and education.

Leadership — DHC leadership in health system planning implies a principal role in guiding the process and providing example.

Local — serving a particular district (as defined above), either in part or in its entirety; generally considered a geographic distinction.

Local government DHC member

Definition Proposed by ADHCO Membership Committee 1993

A local government DHC member is generally *an individual who is designated or nominated by a local government as its representative.* Such individuals may be either an elected member of the local, county, regional or First Nation government (e.g., councillor, alderman, reeve or First Nation Council member) or a non-elected member of

the community-at-large designated or nominated by the Council as their representative to the DHC.

Memorandum of Understanding — an accountability mechanism required by Management Board of Cabinet of all government agencies to "deal with the linkages between the agency and the parent Ministry and establish the administrative ground rules of an agency." It is an articulation of accountability and linkages, based on defined and agreed upon definitions of roles and responsibilities.

Partner/partnerships — associates or colleagues who play on the same team, implying equality of relationship and concordance of goals, aspirations; in this document, the JTF uses partners to indicate the following: MOH, MCSS and DHCs.

Planning — *Planning is preparation for the future by analysis and examination of alternative courses of action, with the purpose of achieving desired objectives. To be useful, planning must be capable of implementation; it must take into account political, social and economic realities and be reasonably sure of public acceptance...* (Ontario Council of Health, 1977)

Planning is an ongoing cyclical process. Decision-making is not the end-product but the first step in a recurrent cycle; it must be followed by implementation, monitoring of the process of implementation and evaluation of the results. (Ontario Council of Health, 1977).

Provider — a person who is involved in the provision of health services including members of the medical or allied health disciplines; persons engaged in the management or administration of health services, including program/facility administrators and members of boards of trustees of health agencies.

Definition Proposed By ADHCO Membership Committee 1993
In general, a provider member is any *...individual who is, or has been within the past five years:*

- *involved in the management or governance of a health or health related social service organization or agency (funded by the Ministry of Health or the Ministry of Community and Social Services) or employed in the direct delivery of human health care services or health-related social services; or*

- *a member of a regulated or registered health profession or a para-professional in either health or health related social services; or*

- *trained or in training as a professional or para professional in either health or health related social services.*

Reform, health system — "reform" implies substantial change for improvement, by removal of faults; principles of reform identified by the Ministry of Health:

1. Improve system management to ensure effective use of scarce resources;
2. Ensure that all planning and service delivery in Ministry programs...is done on the basis of reliable, needs-based, population health data and analysis;
3. Attain the highest possible quality of service;
4. Ensure that at every level, through consumer and worker involvement, appropriate accountability mechanisms are built into every Ministry program.

The MOH has used these principles to reform the system primarily through a sectoral/programmatic perspective.

Reform, sectoral — to create change through individual sectors within the health system, such as mental health, long term care; sectors can be programmatic, geographic or population-based.

Regional — may be defined or circumscribed geographically or by population, but implies an area or population greater than a district but smaller than the province. The Ministry of Health has six regions delineated by coterminous geographic boundaries.

Responsibility — the quality or state of being responsible or accountable, i.e., liable to be called upon to answer for one's actions or decisions;

Resources — ingredients or components which facilitate the means to accomplishing objectives. Resources for planning include data and information, individuals with particular skills, equipment such as computers, and funds.

Roles — an assigned or assumed function or task.

Stakeholders — individuals or groups representing the interests of their constituents, who have an interest in the particular issue under discussion; stakeholders in the health system include consumers, health professionals, planners.

Strategic planning — a set of concepts and procedures to guide fundamental decisions and actions which will shape the health system, through the identification of issues, establishment of system goals and development of actions.

System — a group of units so combined as to form a whole and to operate in unison; "health system" implies the collection of parts: sectors, care and support providers, organizations, consumers, which make up the entirety of health care/maintenance/protection.

Appendices

Appendix A: JTF Terms of Reference

1. Purpose of the Task Force

The purpose of the Joint Task Force (JTF) is to define the practical roles and mandates of District Health Councils (DHCs), as they relate to the Ministry of Health and, with respect to long term care reform, as they relate to the Ministry of Community and Social Services, to ensure adequate resourcing for these roles and mandates, and to maximize positive relationships among these three partners in health and social services system reform.

In achieving the purpose, the JTF may also identify — and when feasible, explore — the relationship of the roles and mandates of these three partners with the roles and mandates of other stakeholders in health and social services system reform.

2. Desired Outcomes/Endpoints of JTF Activities

It is expected that JTF will:

1. reach an agreement on the role of planning in system reform;
2. clearly define the planning roles of the MOH and DHCs in health system reform, and of the MOH, DHCs and MCSS in long term care reform at the provincial, regional (area-wide) and local levels, including differentiation among the respective partners' roles;
3. identify which components of these roles and the associated issues will be explored by JTF and/or its work groups;
4. anticipate immediate, medium-term and long-term demands within the roles of the respective partners;
5. clearly define the responsibilities associated with each of the planning roles/aspects of planning, including responsibilities of each partner to the other partners;
6. outline the infrastructure and resource needs to carry out these responsibilities for planning at each level;
7. recommend a structure and process for linking the planning functions to other aspects of health and social system reform and management;
8. achieve the support of the Minister of Health and the Minister of Community and Social Services for JTF's recommendations;
9. recommend a process for enlisting stakeholder support for the defined planning roles in integrated planning of health and social services.

Task Force Membership

Co-Chairs

Jodey Porter	Assistant Deputy Minister, Health Strategies Group, Ministry of Health
Joy Warkentin	Past Chair, Association of District Health Councils of Ontario

Members

Jane Bartram	Special Advisor, Policy Issues, Health Strategies Group, Ministry of Health
David Bogart	Director, Information, Planning and Evaluation Branch, Ministry of Health
Colleen Blight	Chair, Cochrane District Health Council
Louise Demers	Executive Director, Waterloo Region District Health Council
Jessica Hill	Director, Community Mental Health Branch, Ministry of Health
Perry Kendall	Special Advisor, Long-Term Care and Population Health, Ministry of Health
Pierre Lalonde	Area Manager, Long-Term Care, Ottawa-Carleton, Ministry of Community and Social Services
Doug Lawson	Past Chair, Essex County District Health Council; Past Chair of the Provincial Association of Chairmen of District Health Councils of Ontario
Marlene Longdon	Executive Director, Halton District Health Council
Betty McIver	Executive Director, Kingston, Frontenac, Lennox and Addington District Health Council
Nancy Nagawker	Chair, Hamilton-Wentworth District Health Council [Alternate Member]
Judi Richter Jacobs	Director, Community Services Branch, Ministry of Community and Social Services
Ken Whiteford	Chair, Association of District Health Councils of Ontario
Lorne Zon	Executive Director, Metropolitan Toronto District Health Council

Expert Participants

Monique Begin	Dean, Faculty of Health Sciences, University of Ottawa
John Butler	Executive Director, Association of District Health Councils of Ontario
Stephen Dibert	Strategic Resource Group, Premier's Council on Health, Well-Being and Social Justice
Susan Goodman	Executive Director, Hamilton-Wentworth District Health Council
Lynda Hessey	Executive Director, Durham Region District Health Council
Paul Huras	Executive Director, Thames Valley District Health Council
Peter McKenna	Chair, Rideau Valley District Health Council
Carole McKeough	Legal Advisor, Legal Services Branch, Ministry of Health
Dawn Berry Merriam	Assistant Executive Director, Haliburton-Kawartha and Pine Ridge District Health Council

Gail Siler	Health Consultant, Toronto
Duncan Sinclair	Vice Principal of Health Sciences, Queen's University
Jim Whaley	Chair, Provincial Executive Directors Group
John Wilson	Chair, Algoma District Health Council

Project Staff Team

Vandna Bhatia	Metropolitan Toronto District Health Council
Ingrid Farag	Ontario Ministry of Health
David Hodkin	Association of District Health Councils of Ontario
Carol Hynds	Association of District Health Councils of Ontario
Maureen Quigley	Facilitator, Maureen Quigley and Associates
Nancy Shosenberg	Project Coordinator, Association of District Health Councils of Ontario
Doreen Thibert	Ontario Ministry of Health

Project Support Services

Nicole Chrétien-Proulx	Nortexte, inc.
Muriel Hostettler	Ottawa-Carleton Regional District Health Council
Maracle Press	Oshawa
Jane Stockwell	Stockwell∗Iacona Text & Design
Ann Welsh	Ann Welsh Communications Inc.

Annexe A : Mandat du groupe de travail mixte

1. But du groupe de travail

Le groupe de travail mixte (GTM) vise à définir les rôles et les mandats que les conseils régionaux de santé (CRS) seront appelés à assumer concrètement, par rapport au ministère de la Santé, et dans le cadre de la réforme des soins de longue durée, par rapport au ministère des Services sociaux et communautaires, et ce, afin d'assurer l'affectation de ressources adéquates pour assumer ces rôles et ces mandats, en plus de maximiser l'instauration de rapports positifs entre ces trois partenaires participant à la réforme du système des services de santé et des services sociaux.

En atteignant ce but, le GTM pourrait également déterminer, et possiblement explorer, les liens entre les rôles et les mandats conférés à chacun de ces trois partenaires et ceux assumés par d'autres intervenants qui participeront à cette réforme du système des services de santé et des services sociaux.

2. Résultats escomptés des activités du GTM

Le groupe de travail mixte est censé :

a) Convenir du rôle de la planification dans le cadre de la réforme du système.

b) Définir clairement les rôles de planification assumés par le ministère de la Santé et par les CRS dans le cadre de la réforme du système de santé, sans oublier ceux conférés au ministère de la Santé, aux CRS ainsi qu'au ministère des Services sociaux et communautaires dans le cadre de la réforme des soins de longue durée, tant sur la scène provinciale que régionale (entre les districts) et locale, y compris la distinction entre les rôles conférés à chaque partenaire.

c) Déterminer quelles composantes de ces rôles et quels sujets connexes il examinera ou chargera ses groupes de travail d'analyser.

d) Prévoir les exigences immédiates ainsi qu'à moyen et à long terme associées aux rôles conférés à chaque partenaire.

e) Définir clairement les responsabilités associées à chacun des rôles de planification ainsi que des volets de la planification, y compris les responsabilités de chaque partenaire envers les autres partenaires.

f) Préciser l'infrastructure et les ressources requises pour s'acquitter de ces responsabilités de planification à chacun des paliers.

g) Recommander une structure et un processus permettant de relier les volets de planification aux autres volets de la réforme et de la gestion du système des services de santé et des services sociaux.

h) Faire appuyer ses recommandations par le ministre de la Santé et le ministre des Services sociaux et communautaires.

i) Recommander un processus permettant d'obtenir l'appui des intervenants relativement aux rôles de planification établis dans le cadre de la planification intégrée des services de santé et des services sociaux.

Composition du groupe de travail mixte

Co-présidentes

Jodey Porter	Sous-ministre adjointe, Groupe des stratégies de la santé, ministère de la Santé
Joy Warkentin	Présidente sortante, Association des conseils régionaux de santé de l'Ontario

Membres

Jane Bartram	Conseillère spéciale en politiques, Groupe des stratégies de la santé, ministère de la Santé
David Bogart	Directeur, Direction de l'information, de la planification et de l'évaluation, ministère de la Santé
Colleen Blight	Présidente, Conseil régional de santé du district de Cochrane
Louise Demers	Directrice générale, conseil régional de santé du district de Waterloo
Jessica Hill	Directrice, Direction des services communautaires de santé mentale, ministère de la Santé
Perry Kendall	Conseiller spécial, Soins de longue durée et santé de la population, ministère de la Santé
Pierre Lalonde	Chef de secteur, Soins de longue durée, Ottawa-Carleton, ministère des Services sociaux et communautaires
Doug Lawson	Ancien président, Conseil régional de santé du comté d'Essex; ancien président, Association provinciale des présidents des conseils régionaux de santé de l'Ontario
Marlene Longdon	Directrice générale, conseil régional de santé de Halton
Betty McIver	Directrice générale, conseil régional de santé de Kingston, Frontenac et Lennox & Addington
Nancy Nagawker	Présidente, Conseil régional de santé de Hamilton-Wentworth (membre suppléante)
Judi Richter Jacobs	Directrice, Direction des services communautaires, ministère des Services sociaux et communautaires
Ken Whiteford	Président, Association des conseils régionaux de santé de l'Ontario
Lorne Zon	Directeur général, Conseil régional de santé de la communauté urbaine de Toronto

Participants à titre d'experts-conseils

Monique Bégin	Doyenne, Faculté des sciences de la santé, Université d'Ottawa
John Butler	Directeur général, Association des conseils régionaux de santé de l'Ontario
Stephen Dibert	Groupe des ressources stratégiques, Conseil du premier ministre sur la santé, le bien-être et la justice sociale
Susan Goodman	Directrice générale, Conseil régional de santé de Hamilton-Wentworth

Lynda Hessey	Directrice générale, conseil régional de santé du district de Durham
Paul Huras	Directeur général, Conseil régional de santé de Thames Valley
Peter McKenna	Président, conseil régional de santé de Rideau Valley
Carole McKeough	Conseillère juridique, Direction des services juridiques, ministère de la Santé
Dawn Berry Merriam	Directrice générale adjointe, conseil régional de santé de Haliburton, Kawartha et Pine Ridge
Gail Siler	Experte-conseil en santé, Toronto
Duncan Sinclair	Vice-doyen de la faculté des sciences de la santé, université Queen's
Jim Whaley	Président, *Provincial Executive Directors Group*
John Wilson	Président, Conseil régional de santé d'Algoma

Personnel assigné au projet

Vandna Bhatia	Conseil régional de santé de la communauté urbaine de Toronto
Ingrid Farag	Ministère de la Santé de l'Ontario
David Hodkin	Association des conseils régionaux de santé de l'Ontario
Carol Hynds	Association des conseils régionaux de santé de l'Ontario
Maureen Quigley	Animatrice, *Maureen Quigley and Associates*
Nancy Shosenberg	Coordonnatrice de projet, Association des conseils régionaux de santé de l'Ontario
Doreen Thibert	Ministère de la Santé de l'Ontario

Services de soutien

Nicole Chrétien-Proulx	Nortexte, inc.
Muriel Hostettler	Conseil régional de santé du district Ottawa-Carleton
Maracle Press	Oshawa
Jane Stockwell	*Stockwell*Iacona Text & Design*
Ann Welsh	*Ann Welsh Communications Inc.*

Appendix B: Statement of Mission, Mandate and Principles of the Association of District Health Councils of Ontario

The **Association of District Health Councils of Ontario** is a voluntary Association established to implement the following mission:

Mission Statement

- To strengthen the capacity of District Health Councils to undertake comprehensive planning to meet the future health needs of their communities;

- To develop and enhance the capacity of District Health Councils to become an active partner in provincial/regional planning to meet the future health needs of the people of Ontario;

- To assist District Health Councils to establish and maintain a recognized role for DHCs at the provincial level with the Premier's Council on Health, Well-being and Social Justice, Government Ministries, and other relevant provincial associations.

Mandate

The **Association** has received from District Health Councils the following mandate in support of local planning:

- To serve as a forum for information exchange and problem resolution among all District Health Councils;

- To serve as the forum for communication and problem solving between District Health Councils and the Ministry of Health in matters which are of collective interest to District Health Councils, or to the Ministry of Health;

- To speak on behalf of all District Health Councils to the Ministry of Health on matters that relate to the effective functioning of Councils;

- To provide a proactive voice to the Ministry of Health, on behalf of District Health Councils, on policy or planning matters which Councils wish to have addressed;

- To facilitate interaction and sharing of experience among District Health Councils which are in the process of implementing the enhanced role;

- To establish and maintain linkages on behalf of District Health Councils with Government Ministries whose programs and policies have an impact on the planning activities and relationships of District Health Councils;

- To assess the appropriateness of collective District Health Council involvement in specific planning assignments initiated by the Ministry of Health;

- To oversee the planning of the annual Action Centre Conference.

Governing Principles

The following principles shall govern the conduct of the **Association**:

- that there should be an Association of District Health Councils of Ontario, to act as the collective voice of District Health Councils in Ontario;

- that the Association must support and serve local District Health Councils;

- that, except as specifically permitted in the By-Laws, the Association may not interfere with the direct communication of advice from a District Health Council to the Minister and Ministry of Health on health matters affecting the jurisdiction of that District Health Council;

- that the Association shall not be allowed to develop into a level of bureaucracy between local communities and the Ministry of health;

- and that the structural and organizational details of the Association should be determined on the basis of what will produce an effective and efficient Provincial Association.

Appendix C: Charts and Tables

Chart I: Implementation Timelines

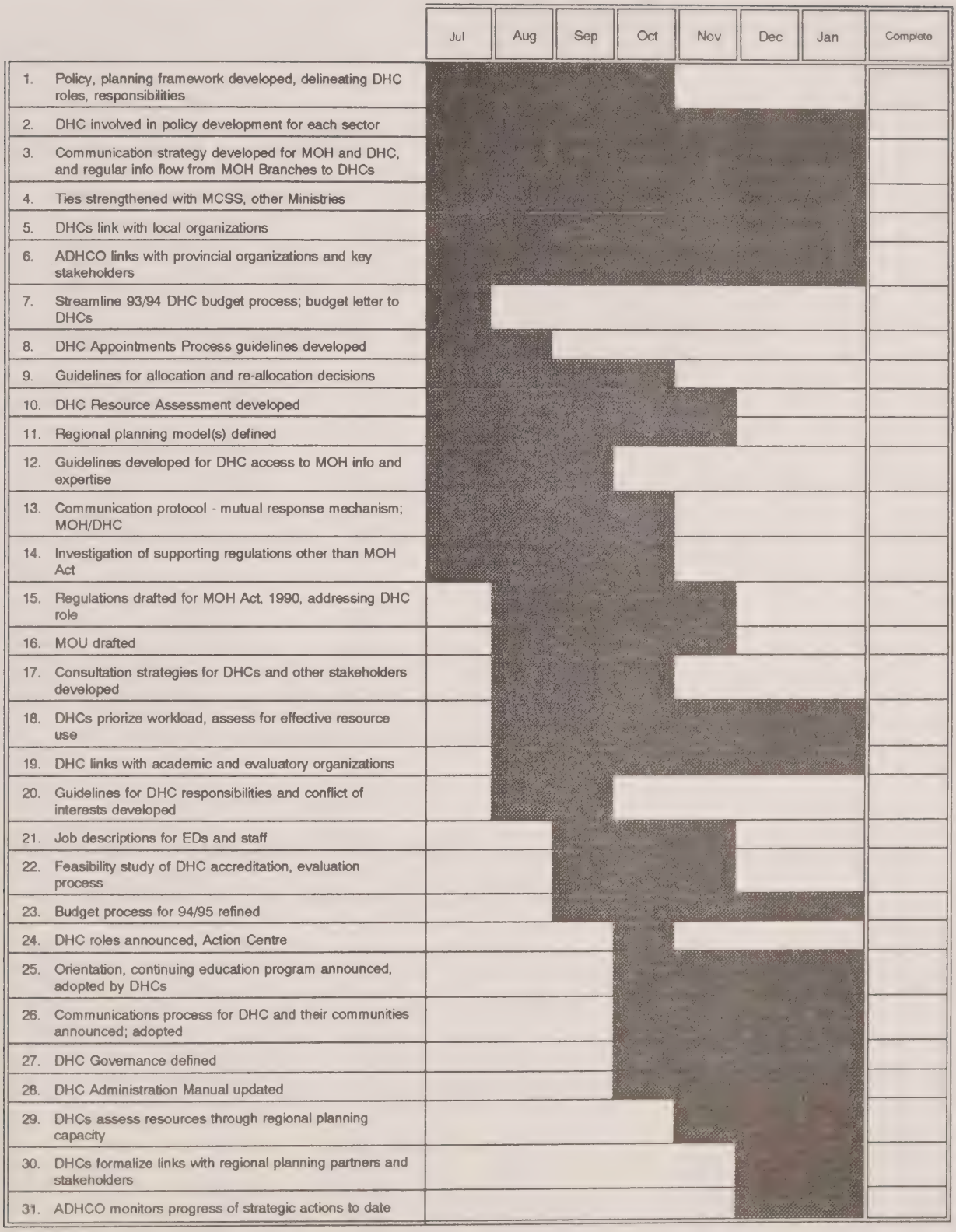

Table II: Implementation of Strategic Actions

SUMMER 1993	SUMMER	SUMMER	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	JANUARY
Policy and planning framework and statements developed indicating leadership of DHCs in planning **MOH, IPEB, ADHCO** *I.4.I,ii; I.5.I,ii*	Investigation of legislation other than *MOHA* supporting DHCs role **LEGAL SERVICES BRANCH, MOH, ADHCO** *I.2.I,ii*	Nomination, appointment process and identification of skills required of appointees to DHCs completed **ADHCO/MOH Membership Committee** *II.5.I,ii*	Communication protocol of mutual response mechanism for DHC advice to MOH **MOH, DHCs/ADHCO** *I.6.; I.7.I; II.1.I,ii,iii,iv*	DHC Administration Manual updated **IPEB, Special Committee of ADHCO** *II.1.v*	DHCs formalize linkages with regional planning partners and other stakeholders **DHCs, IPEB** *IV.4.i*	Budget process refined for 1994/95 **IPEB, PED** *II.3.i*	Feasibility study for DHC accreditation/evaluation process completed **PED** *II.7.i*
Active involvement of DHCs, IPEB in policy development **IPEB, ADHCO** *I.5.ii; III.3; III.3.i*	Streamlined 1993/94 budget process for DHCs completed **IPEB, PED** *II.3.I*	Regulations drafted for MOH Act, 1990, addressing DHC role **Legal Services Branch, MOH** *I.1.I,ii; III.1.i*	Develop communication strategy for MOH and DHCs **MOH, Com. and Mkt. Committee, ADHCO** *II.1.i*	DHC roles announced to DHC volunteers and staff at Action Centre **Minister** *III.2*	DHCs adapt communication strategies developed by ADHCO Marketing & Communication Committee and Membership Committee to reach communities **DHCs** *II.1.vii,viii,ix*		Formalized accountability linkages between DHCs and other stakeholders for regional planning established through public statements, policy **MOH, DHCs, ADHCO** *III.1; IV.4.ii*
Regular correspondence of information from MOH Branches to DHCs **MOH, IPEB, ADHCO** *II.1.iv*	Resource assessment of DHC current and future needs for system reform and regional planning **IPEB, PED** *II.4.I,ii*	MOU drafted **MOH, Special Committee of ADHCO** *I.3.i*	Formalized and uniform job descriptions and core curriculum developed for EDs and staff **PED, ADCHO** *II.6.ii,iii*	Orientation, continuing education programs for volunteers and staff developed **ADHCO, PED** *I.8.i,ii,iii*	MOU draft completed **MOH, Special Committee of ADHCO** *I.3.i*		Administration Manual revised **IPEB, Special Committee of ADHCO** *II.1.v*
Ties strengthened with MCSS, other Ministries affecting the determinants of health **MOH, DHCs** *IV.3; IV.3.i*	Guidelines for allocation & reallocation decisions, including saved resources developed **MOH, PED, DHCs** *II.2.i,ii*	Development of regular consultation between DHCs, stakeholders for planning, including for human resources **DHCs** *IV.1; IV.1.i; IV.2; IV.2.i*	Feasibility study of DHC accreditation/evaluation process undertaken **PED** *II.7.I*	Communication process for DHCs to reach local communities to be announced **ADHCO** *I.8.iv*	Regulations for MOH Act that address DHC roles completed **Legal Services Branch, MOH, ADHCO** *I.2.i,ii*		Resource assessment of DHC requirements completed **IPEB, PED** *II.4.i,ii*
DHCs seek out links with other local organizations involved in health **DHCs** *III.2.i; IV.1.i; IV.2.ii,iii; IV.4; IV.4.i*	Guidelines for DHC access to MOH info and expertise developed **IPEB, PED** *II.1.vi*	DHC initiation of links with academic and research organizations for evaluative information **DHCs** *IV.2.iii; IV.5.i*	Further refinements made to budget process for 1994/95, including core and special project guidelines, equity among DHCs **IPEB, PED** *III.3.i*	Governance modele defined **TQM Committee, ADHCO** *II.6.i*	DHCs assess use of resources through regional planning capacity **DHCs, MOH** *III.6.; III.6.I*		First Report Card — monitor implemented strategic actions to date **ADHCO**
ADHCO seeks out links with other provincial organizations involved in health **ADHCO** *IV.4.ii*	Regional Planning Steering Committee develops model **Regional Planning** *III.4.I,ii; III.5.I,ii; III.6.I*	Mechanisms developed by DHCs to priorize workload for effective use of resources **DHCs** *II.3.ii,iii; III.6.i*	Guidelines for DHC responsibilities and conflict of interest developed **MOH, Special Committee of ADHCO** *II.2.iii*				

Appendix D: Historical Development of District Health Councils in Ontario

Compiled by Vandna Bhatia for the Joint Task Force, May, 1993

1964 and 1965: *The Report of the Royal Commission on Health Services*, Volume I and II (The Hall Commission)

The Hall Commission report concluded that "an essential element in the provision of the best possible health care for Canadians was the improved organization of health services." The Commission recommended three levels of organization:

- **Provincial Health Planning Councils**
  "To ensure democratic participation in the setting of goals and objectives of the health services programmes, a provincial Health Planning Council should be appointed by the provincial government from panels nominated by professional bodies, voluntary organizations, university, municipal, farm, business, labour and other representative associations."

- **Regional and Local Health Planning Councils**
  "Where the size or diversity of a province warrants it, regional and local or municipal health planning councils should be established..."

1969: *The Regional Organization of Health Services, Part I*, Report of the Ontario Council of Health

Based on the findings and recommendations of the Hall Commission, the Ontario Council of Health also accepted the desirability of establishing a system of regional organization of health services. This system of regional organization "should provide the most effective total health service for the people of Ontario". This organization should also have three tiers, with the following responsibilities:

- **The Province**
  To provide policy guidance, set standards and assess the overall effectiveness of the system; to collect and analyze data for evaluation of effectiveness; to maintain overall financial control, with delegation of financial authority and responsibility to the appropriate regional or district council.

- **The Regional Council**
  To plan for "the provision of health services within its region based on provincial guidelines", to ensure that "efficient, effective and economic use is made of available manpower, facilities and funds", "to exercise financial authority commensurate with their assigned responsibilities."

- **The District Council**
  To organize the provision of health care for the residents of the district and coordinate operational functions within provincial guidelines and the regional planning programme; to exercise "financial authority commensurate with its assigned responsibilities."

1970: *The Regional Organization of Health Services, Part II: A Proposed System*, Report of the Ontario Council of Health

This report of the Ontario Council of Health further elaborates on the 1969 report with the following sample of recommendations:

1. "THAT regional and district councils be given assurance that every proposal for new health care facilities and services, modifications of existing facilities and additions to existing facilities, requiring financial support either capital or operating from provincial sources, shall be routed through the respective district and regional health councils for their approval or otherwise.

2. THAT the authority of regional and district councils be established by legislation and that the Province establish policies, standards and guidelines to provide the framework within which regional and district councils will function.

6. THAT district health councils be composed of representatives from among: professional and technical interests; local government; voluntary agencies and consumers. All

members will be appointed by the Minister of Health from a short list of nominees submitted by the relevant groups.

7. THAT the Provincial Government take immediate action to introduce a regionalized system on a phased basis with the co-operation of the people in the areas involved.

9. THAT the Province initiate those changes in the provincial organization, functions and financial arrangements which are necessary to support a regionalized system and to provide an effective interface between the Provincial Government and the regional health councils.

The report itself is a very strong endorsement of relatively autonomous and authoritative regional and district bodies. It provides greater detail than the first report about the functions and responsibilities of each level of organization.

1972: *An Implementation Plan for the New Orientation and Structure of the Ministry*, Ontario Ministry of Health

In 1972, the Ministry of Health was restructured to achieve two main goals:

1. To reorganize the Ministry to eliminate separate compartments, to effect decentralization and to make it possible for all decisions to be made within the context of an overall program area;

2. To create DHCs as an essential component in local community partnerships to achieve the above objectives.

The principles of the restructuring were as follows:

1. All health needs will be served by one comprehensive program.

2. The responsibility for health care will be shared by the Ministry and District Health Councils.

3. The public will be strongly represented on District Health Councils, and will participate in the development of district programs.

4. Greater responsibility and accountability for health care will be shifted to the community.

Further, the Plan indicated that the Ministry would be responsible for the development of one comprehensive health care program to relate all areas of special interest. Three primary functions — setting standards, ensuring the delivery of services, and financial management — replaced program areas as the basis for the organization of the Ministry.

Planning was to be "a coordinated effort within the Ministry, and at the District level, in relation to needs and priorities [with] managerial responsibilities for the delivery of services...clearly separated from the technical responsibilities for setting standards for health care."

1974: *Report of the Health Planning Task Force*, (The Mustard Report)

The Health Planning Task Force was asked to "develop proposals for a comprehensive plan to meet the health care needs of the people of Ontario."

The Task Force identified two levels of care for which services should be organized: primary and secondary. Focusing on the primary care sector, the Task Force proposed District Health Councils for planning and Area Health Services Management Boards for operations at the local level, and a Regional Director and regional office to act on behalf of the Ministry of Health at the community level.

With respect to DHCs, the Task Force made the following specific recommendations:

1. District Health Councils should be established throughout the province as rapidly as possible. These councils should be established by statute and given the responsibility for recommending to the Ministry plans for the delivery of health care in each district. These plans would include the programmes to be carried on, required manpower and the use and location of facilities. The District Health Councils should also be responsible for ensuring that mechanisms exist for maintaining quality of care in the district.

2. Area Health Services Management Boards should be created by statute to facilitate the integration of the delivery of care in the primary and secondary care sectors in areas within a district...

3. Regional Directors for health services should be appointed to act for the Minister in carrying out his responsibilities in the health care system throughout the province...The Director's role is to assist District Health Councils, Area Health Services Management Boards and institutions in carrying out their statutory responsibilities...

1974: *Report, Reaction, Response: The Health Care System in Ontario.* Ontario Ministry of Health

In this report, the Ministry of Health responded to the recommendations of the Health Planning Task Force. Based on an extensive consultation, the Ministry had the following responses to the above three recommendations:

1. Given the positive support from the public, District Health Councils had already begun to be established, with the Ministry's Area Planning Coordinators working with local communities to move these Councils to an operational status. The Ministry had also charged the Ontario Council of Health to establish a Task Force on District Health Councils to "prepare a detailed report on organizational and functional options available to District Health Councils", and had prepared the *Action Centre* guide for DHCs.

2. The Area Health Services Management Boards were rejected outright, primarily because of the negative response from the public. The major concern was the establishment of another layer of management, and the Ministry saw that "imposing such a grouping, in the face of complete opposition of the public, would be both unproductive and undesirable." It did pledge, however, to encourage similar local mechanisms "under the leadership of District Health Councils."

3. The Regional Directors recommendation was not adopted, keeping the Area Planning Coordinators established in the 1972 Ministry restructuring in place as the link between the Ministry and DHCs.

1974: *The District Health Council: Action Centre in Ontario's Health Care Delivery*, Ontario Ministry of Health

The Ministry of Health produced this document, also commonly known as "The Black Book" because of its black cover, to outline the "basic philosophy behind the District Health Council concept." DHCs were established by the government "as a means whereby more decisions in health care matters may be made at the local level." As well as setting guidelines for the establishment of DHCs, the Black Book identified the goals and priorities of District Health Councils.

The original terms of references gave DHCs the responsibility to:

- identify district health needs and consider alternative methods of meeting those needs that are consistent with provincial guidelines;
- plan a comprehensive health care program and establish short-term priorities that are consistent with long-term goals;
- coordinate all health activities and ensure balanced, effective and economical service, satisfactory to the people of the district;
- work toward co-operation in the social development activities for the district.

Short term priorities identified by the MOH required DHCs to:

- inform Council members about the health care system;
- inform the community on the issues and the need for coordinated, integrated planning;
- build an image of credibility and competence in the community;
- build effective relationships with the provincial government and local planning and delivery bodies;
- develop a favourable climate for health planning;

- develop, within this climate, a set of priorities;

- take the initiative in well-defined areas on specific issues;

- deal promptly and competently with issues referred to the local Council by the community or the Ministry;

- utilize a data base to support the planning, educational and other activities of Council. The Council will use the resources available through Ministry information services as a primary source of regional statistical data, supplemented, if necessary, by data collection of a nature applicable to Council.

1975: *District Health Councils*, Report of the Task Force on District Health Councils of the Ontario Council of Health

Building on the past recommendations of the Ontario Council of Health, the Task Force was asked to review the existing guidelines, status and functioning of planned and existing DHCs, and to propose guidelines consisting of available options for the establishment, functional organization and administration of district health councils.

The Task Force made a total of 26 recommendations to the Minister of Health in the following areas:

- district boundaries;
- terms of reference and authority;
- formulation and composition of steering committees and district health councils; membership tenure;
- interagency relations;
- organization and finance.

Overall, the Task Force encouraged the further development of DHCs for health services, based on established regional government or county boundaries and serving a minimum of 100,000 people. DHCs should have strong ties with health science centres in their respective region, and be responsible for the following:

- recommendations to the Ministry on the "curtailment, expansion and initiation of programs and enact legislation, if necessary, to allow flexibility in assignment of functions now designated by law to certain organizations";

- planning for health human resource needs, in conjunction with the Health Science Complexes;

- coordinate and integrate programs and services, with the incentive of retaining resource savings from this to channel toward other local priorities;

- act as "catalyst between consumers and providers in initiating new programs".

The report suggested that DHCs not be involved in the day-to-day operation of services and programs, but retain overall responsibility for the planning and overall administration of services in their district.

The Ministry of Health was recommended to take on the following:

- organize a formal structure for exchange of information, experience and ideas, as well as for the resolution of problems among DHCs;

- disclose complete expenditure and estimates information for health in districts to the DHCs, and "not make decisions regarding the allocation of funds without the advice of the DHC."

1977: *The Planning Function of District Health Councils*, Report of the Ontario Council of Health.

This report of the Ontario Council of Health identified the planning functions and responsibilities of both the Ministry and DHCs. It focused on three tiers of planning: operational (1 to 5 years), comprehensive (up to 10 years) and strategic (10 to 25 years).

The planning process discussed in this report contained the following elements: determination of need, collection and interpretation of data, identification of priorities and options, the evaluation of the quality of health services, and education of decision-makers and stakeholders.

Working relationships between DHCs and other stakeholders necessary to the planning process were identified, particularly the health professions, health agencies, and health science centres. Communication and coordination of DHC activities with the Ministry of Health were to be facilitated through the Area Planning Coordinators and Area Health Services Committees, while greater coordination and communication amongst DHCs themselves was identified as a need.

Relationships between DHCs and stakeholders outside the health care system were also recognized as imperative to effectively coordinate health related services, both at the local level as well as across ministries at the provincial level. Community involvement was regarded as problematic since Council members had little accountability to their community and tended to identify with particular interests rather than the community as a whole.

Finally, the report discussed resource issues with respect to planning, in particular a sound data base for planning and monitoring services, adequate human resources with the necessary specialized planning skills, links with the research and expertise in health science centres, and sufficient funding.

1981: *The Organization of District Health Councils in Ontario*, Report on a Research Project, Maureen Dixon

This report was based on a research project conducted by the author in conjunction with three DHCs: Hamilton-Wentworth, Kenora-Rainy River and Ottawa-Carleton, to identify the most effective forms of organization for the DHCs. It occurred from 1977 to 1981, taking the form of three case studies based on interviews, observations and interactions with members of the DHCs themselves. Beginning with an historical overview of the development of regionalization policy and DHCs in Ontario, the report discusses the findings in each of the three cases studies. It follows with an analysis of the basic role of DHCs; the responsibilities and roles of Council members and Chairs; the committee structures and organization for planning; and the roles and responsibilities of the Executive Director and staff.

The conclusions of the author did not take the form of prescriptive solutions to the problems identified through the study, but rather raised generic issues for further consideration in the development of DHCs:

- "the paradox intrinsic in schemes for decentralization — the desire to allow decisions to be made at a local level while retaining central control and accountability;

- "the essentially political nature of the decision-making process, portrayed in the debates about the natural health district, relationships to local government and relationships to the public;

- "the feasibility of combining in one organization the functions of long-term planning and community involvement;

- "the practicality of placing accountability for coordinated planning and for management with different parts of a service-providing system. (p.158)

Dixon concludes: "...in the final analysis, unless (productive) change can be rooted in a more profound understanding of the political and organizational forces at work, it can only be ameliorative." (p. 159)

1982: *Ministry of Health Policy Guidelines*, Ontario Ministry of Health

In 1982, the Minister of Health outlined "Four Pillars of Health Policy":

1. Reducing the "traditional emphasis on acute hospital care" through the establishment of beds: referral population guidelines, focus on ambulatory care and other community-based alternatives to in-patient care.

2. Increasing emphasis on prevention and community health services.

3. Promoting increased personal responsibility for health through public education programs.

4. Decentralization of planning through district health councils because "no one is better able to assess and co-ordinate the health care resources of a community than the people who live and work there." DHCs are to examine the available resources and needs and make recommendations on the health priorities for their communities.

1985: *Developmental Assessment of District Health Councils*, Ontario Ministry of Health

In 1979, the Ministry contracted an external group to develop an assessment tool for the review of DHCs. This tool was utilized by a steering committee, chaired by John Last (hence, the Last Committee), to complete an assessment by 1983. In 1985, the Ministry responded to the assessment.

The Committee, found DHCs needed to devote more time to the development of longer term health plans for their communities and improving their role in the coordination of local health planning. Of particular note was the problematic relationship often encountered between hospitals and DHCs.

The Committee recommended the Minister and Ministry of Health ensure full support for DHCs, particularly in the provision of adequate resources for them to fulfil their responsibilities. Also, the Ministry needed to work at developing greater acceptance and acknowledgement of the role of DHCs as major contributors to the health care system.

Overall, the Committee indicated that the DHC system was working well, with increasing credibility and responsibility over time. A series of 42 recommendations dealing with planning and management issues, directed at both the Ministry and DHCs, were made to further develop and enable DHCs to fulfil their responsibilities in an efficient, effective and credible manner.

The Ministry, in its response to the Committee's report, made "a commitment to facilitate local planning by ensuring that councils have the most up-to-date information possible on Ministry policies and guidelines, and, to provide, within the limits of practicality and available resources, the data required for effective local planning..." With respect to Ministry/DHC relationships, the Ministry stated: "The Ministry's commitment to the maintenance of a positive and strong working relationship, supported primarily by the area planning coordinators is a priority."

1989: *District Health Councils: Partners in Health Planning*, Provincial Association of Chairmen and the Ministry of Health

The *Partners in Health Planning* report endorsed an enhanced role for DHCs, beyond their original mandate, to include the following four advisory areas:

1. Allocating funds;

2. Determining human resource requirements in the health field;

3. Strengthening area-wide planning;

4. Achieving the integration of health and social services planning.

The adoption of the additional roles and responsibilities was to take place gradually, with individual DHCs deciding the order, manner and extent of their involvement with each of the enhanced roles. In return, the Ministry committed to actively promoting the enhanced role; supporting operational reviews of DHCs to determine the appropriate resources required for effective planning; providing current provincial and regional data for planning; and, giving timely and sound policy direction by keeping DHCs informed of provincial policies and guidelines.

Appendix E: Table III: District Health Councils—Dates Established

Order-In-Council	District Health Council	Area of Province Served by DHC (% of population)
	1970's	
December 21, 1973	Ottawa-Carleton Regional	
October 2, 1974	Thunder Bay	
May 7, 1975	Niagara	
June 15, 1975	Cochrane	
October 15, 1975	Haliburton, Kawartha & Pine Ridge	
December 1, 1975	Kenora Rainy River	
January 28, 1976	Thames Valley	
January 28, 1976	Essex	
January 28, 1976	Hamilton-Wentworth	
April 28, 1976	Grey-Bruce	
April 28, 1976	Kent County	
May 26, 1976	Manitoulin-Sudbury	
June 23, 1976	Wellington County	
July 21, 1976	Halton	
June 23, 1976	Brant	
March 9, 1977	Peel	
March 30, 1977	Rideau Valley	
April 13, 1977	Algoma	
June 15, 1977	Lambton	
June 15, 1977	Durham	
November 30, 1977	Waterloo Region	
	1980's	
March 26, 1980	Eastern	
August 20, 1980	Metropolitan Toronto	
August 6, 1981	Haldimand-Norfolk	
September 18, 1981	Kingston, Frontenac & Lennox & Addington	
July 9, 1983	Simcoe County	
April 15, 1988	West Muskoka-Parry Sound	
April 15, 1988	East Muskoka-Parry Sound	90.0
	1990's	
December 6, 1991	Hastings & Prince Edward County	
December 6, 1991	Renfrew County	
December 6, 1991	York Region	
December 9, 1992	Nipissing-Timiskaming	
December 24, 1992	Huron County Steering Committee	
December 24, 1992	Perth Steering Committee	100

Appendix F: Bibliography and List of JTF Working Papers

1. Demers, Louise. *The Rationale for Change.* Paper prepared for the Joint Task Force, February 1993.

2. Hodkin, David. *Lessons Learned From Current Planning Experiences and Models.* Paper prepared for the Joint Task Force, April 1993.

3. Norris, Jan. *Summary of Health System Planning Approaches in Other Jurisdictions.* Paper prepared for the Joint Task Force, April 1993.

4. Joint Task Force. *Proceedings of the Joint Task Force Special Session of the Evolving Mandate Group.* April 1993.

5. Joint Task Force. *Proceedings of the Joint Task Force Special Session on Regional Planning.* April 1993.

6. Ontario, Ministry of Health. *Goals and Strategic Priorities.* January 1992.

7. Ontario, Ministry of Health. *Health Services Planning Framework: A Tool for Planning.* January 1992.

Order Form

Please complete the form below to order any of the reports listed and forward with payment to:

Carol Hynds
Administrative Assistant
Association of District Health Councils of Ontario
4141 Yonge Street, Suite 201
Willowdale ON M2P 2A8

Telephone: (416) 222-1445

Report	# of copies	Unit cost*	Subtotal
1. Summary Report		x $2.50	
2. Summary and Implementation Report		x $2.50	
3. Summary of Health System Planning Approaches in Other Jurisdictions, Jan Norris, April 1993		x $5.00	
4. Proceedings of the Joint Task Force Special Session of the Evolving Mandate Group, April 1993		x $3.00	
5. Proceedings of the Joint Task Force Special Session on Regional Planning, April 1993		x $3.00	
		Total cost	

*Prices apply to photocopying and mailing costs.

Name: _____

Organization: _____

Address: _____

_____

_____

Telephone: _____

ISBN 0-7778-1681-4